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IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-430

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Petitioners,

vs.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

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STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Petitioners,

vs.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

Petitioners pray that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of New Jersey entered in this proceeding on June 18, 1979.

Opinions Below

The opinion of the Supreme Court of New Jersey, entered on June 18, 1979, is reported at 80 N.J. 299, 403 A.

2d 487 (1979) and is appended to this petition as Appendix A. The opinion of the Superior Court of New Jersey, Appellate Division, was entered on March 27, 1978 and is reported at 158 N.J. Super. 241, 385 A.2d 1244 (App. Div. 1978).* It appears as Appendix B to this petition. The determination of the Director of the Division of Medical Assistance and Health Services, dated February 8, 1977, is unreported. It appears as Appendix C to this petition. The recommended findings of fact and conclusions of law of the hearing officer for the Division of Medical Assistance and Health Services, dated October 28, 1976, is unreported. It appears as Appendix D to this petition.

Jurisdiction

The judgment of the Supreme Court of New Jersey declares invalid State Medicaid regulations on the ground that they violate mandatory provisions of the Federal Social Security Act and implementing regulations promulgated by the Secretary of the Department of Health, Eduaction and Welfare. Jurisdiction to review the judgment below by writ of certiorari is conferred upon the Court by 28 U.S.C. §§1257(3) and 2101(c).

Questions Presented

1. Do Sections 1901 and 1902(a)(13)(D) of Title XIX of the Social Security Act, 42 U.S.C. §§1396 and 1396(a)(13)(D), or regulations of the Department of Health,

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*According to New Jersey practice, the opinions of appellate courts in the State are self-executing and no separate judgment is rendered after the rendering of an opinion. Accordingly, the opinions set forth in Appendices A and B are the final judgments of the Courts below.

Education and Welfare adopted thereunder, mandate that a State which participates in the federal Medicaid program must extend medical assistance for inpatient hospital services provided to patients awaiting transfer to lesser care facilities who are no longer in need of acute level care?

2. Does this Court's decision in *Quern* v. *Mandley,* 436 U.S. 725 (1978), preclude an interpretation of 42 U.S.C. §1396, a general purpose clause, as imposing a mandatory funding requirement of all medically necessary services upon a State participating in the Medicaid program?

3. Where a State upon approval by the Secretary of HEW has imposed a limitation upon reimbursement of inpatient hospital services based upon critical budgetary constraints, and where a challenger of the limitation fails to proffer any evidence of its adverse impact upon the inpatient Medicaid hospital population, can there be a finding that the inpatient hospital service coverage does not "reasonably achieve its purpose" within the intendment of 42 C.F.R. §440.230(b)?

Statutes and Regulations Involved

42 U.S.C. §1396 Authorization of Appropriations

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each

fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education and Welfare, State plans for medical assistance."

42 U.S.C. §1396a(a)(13)(D) STATE PLANS FOR MEDICAL ASSISTANCE—CONTENTS

"A State plan for medical assistance must

* * *

(13) provide

* * *

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a-1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter."

42 C.F.R. §440.230(b) SUFFICIENCY OF AMOUNT, DURATION, AND SCOPE

(a) The plan must specify the amount and duration of each service that it provides.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c)(1) The medicaid agency may not deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

N.J.A.C. 10:52-1.2(a)(18) COVERED INPATIENT HOSPITAL SERVICES

Inpatient hospital services rendered after the day it is medically necessary, except [sic] when special circumstances prevent the discharge or transfer of the patient.

Note: The Contractors may reimburse a hospital up to 12 cal[illegible]ar days following the period established medically necessary if special circumstances (social necessity) prevent the discharge or transfer of the patient to his/her home or sheltered boarding home and the hospital has taken effective action to stimulate placement of the patient.

Effective action is defined as telephone notification to the County Welfare Board, Division of Youth and Family Service District Office or other responsible officials within one working day of the time that the stay has been determined to be no longer medically necessary. This telephone contact must be then confirmed in writing.

A copy of the written notification must be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).

N.J.A.C. 10:52-1.2(b):

> Payment for special circumstances (social necessity) is specifically precluded for:
>
> (1) Patients awaiting placement in a Skilled Nursing Facility or Intermediate Care Facility.
>
> (2) Patients for whom a claim has been denied for lack of medical necessity.
>
> (3) Patients who are not eligible recipients as of the date of admission.

Statement of the Case

This case came before the Supreme Court of New Jersey upon certification to the Superior Court of New Jersey, Appellate Division, after the Appellate Division adjudged the limitation upon inpatient hospital services' reimbursement set forth in N.J.A.C. 10:52-1.2(a)(18) and N.J.A.C. 10:52-1.2(b) violative of the objectives of Title XIX of the Social Security Act and regulations of the federal Department of Health, Education and Welfare (hereafter HEW). The Supreme Court of New Jersey affirmed the judgment of the Superior Court, Appellate Division. Petitioners herein are the State agency and officers responsible for supervising the administration of the federal medical assistance (hereafter Medicaid) program in New Jersey.

The State of New Jersey is a participant in the federally funded Medicaid program established by Title XIX of the Social Security Act, 42 U.S.C. §§1396 *et seq.* As such the State has through the Department of Human Services formulated a State plan which, in accordance with 42 U.S.C. §§1396a(a)(1)-(40), generally establishes

criteria for eligibility and the medical services for which Medicaid reimbursement will be made available. Among the categories of health care for which the State provides Medicaid reimbursement are inpatient hospital services. Provisions of the State plan, approved by the Secretary of Health, Education and Welfare and promulgated in the New Jersey Administrative Code, thus establish coverage of all inpatient hospital services without day limitation save for elective cosmetic surgery, diet therapy for exogenous obesity and inpatient hospital services provided where a need for that level of acute care is no longer required. This limitation upon coverage expressly extends to inpatient hospital services provided to a patient who is awaiting transfer from the hospital to his home or to a lesser care facility, such as a nursing home. N.J.A.C. 10:52-1.2(a)(18) and N.J.A.C. 10:52-1.2(b)(1). It has been estimated that if the State's medical assistance program were to be expanded to cover these extended periods of hospitalization, and if federal matching funds were forthcoming, approximately $18.9 million in additional State appropriations would be required.*

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* The $18.9 million figure was based upon a survey of Medicaid hospital providers conducted by the Division of Medical Assistance and Health Services in March, 1978 and use of the average per diem rate paid by the Division that fiscal year. The total State payments for Medicaid benefits for FY1978 was $272,370,400. A lesser amount would be required if HEW were to approve either of two State plan modifications submitted in May 1977 and again following the issuance of the Supreme Court of New Jersey's opinion in this matter: (1) conversion of underutilized hospital beds to nursing home beds with Medicaid payments at the appropriate nursing home level; or (2) payment to hospitals for services provided to patients awaiting nursing home placement at the appropriate nursing home rate. To date that approval has not been forthcoming.

This case arises from an appeal by respondent, Monmouth Medical Center, a provider of inpatient hospital services under New Jersey's Medicaid program, N.J.S.A. 30:4D-1 *et seq.*, from a decision by the Director of the New Jersey Division of Medical Assistance and Health Services which denied in part its claims for reimbursement for services provided to three Medicaid recipients while awaiting placement in the community or lesser care facilities (App. B).* At the hearing conducted before the Division of Medical Assistance and Health Services and in its appeal from the Director's decision to the Superior Court of New Jersey, Appellate Division, the respondent challenged the regulations upon which the denial was based, N.J.A.C. 10:52-1.2(a)(18) and N.J.A.C. 10:52-1.2(b)(1), as inconsistent with federal law. In specific the hospital argued that under federal decisional law, interpreting Title XVIII of the Social Security Act, 42 U.S.C. §§1392 *et seq.* (Medicare) as well as Title XIX of that same act, 42 U.S.C. §§1396 *et seq.* (Medicaid), reimbursement of inpatient services provided by a hospital was mandated even where lesser care placement would be appropriate so long as: 1) the services provided were reasonable and necessary for the well being of the patient; and 2) diligent efforts for placement were made. In defense of its actions the State argued that Title XIX

* A total of 44 days was involved in the challenged denial of reimbursement: 1) a twenty (20) day period from May 8, 1975 through May 28, 1975 in which nursing home placement was sought for Luther Townsend; 2) a five (5) day period from December 5, 1974 through December 10, 1974 in which the hospital staff sought and finally obtained an apartment for Madeline Papikas; and 3) a nineteen (19) day period in which the hospital sought nursing home placement for James Rempkowski. Contrary to the conclusion of the Court below denial of the claim for Ms. Papikas was unrelated to the hospital's delay in securing nursing home placement.

of the Social Security Act granted it discretion to limit coverage for a category of necessary services in order to discourage over-utilization of hospital services and to insure the continued fiscal solvency of the program. In the absence of any showing by the hospital that the Medicaid population would be severely hampered in obtaining necessary inpatient hospital services as a result of this policy, the State contended the objectives of Title XIX were satisfied.

The Appellate Division, in an opinion issued on March 27, 1978 (App. B), rejected the State's arguments, concluding that reimbursement in the instances presented was appropriate since the services provided were "medically necessary."*

Thereafter, the State filed a petition for certification to the Supreme Court of New Jersey seeking review of the decision mandating payment of the three claims; certification was granted on July 11, 1978. 77 N.J. 506, 391 A2d 519 (1978). In a decision rendered on June 18, 1979, the Court, with one Justice dissenting, ruled that the limitation upon coverage embodied in N.J.A.C. 10:52-1.2(a)(18) and N.J.A.C. 10:52-1.2(b)(1) was invalid under the Supremacy Clause of the United States Constitution in that hospitals were unreasonably denied reimbursement for medically necessary care provided to "unavoidably retained" patients (App. A at 16a). As an alternative ground for decision the Court concluded, despite the absence of any proffer of statistical evidence by respondent

* The Court rejected however the hospital's additional contention that the provision of a pre-denial hearing to Medicaid recipients in these cases was constitutionally mandated by the due process clause of the Fourteenth Amendment to the United States Constitution (App. B at 37a to 39). This ruling was later affirmed by the Supreme Court of New Jersey (App. A at 18a).

as to the percentage of the Medicaid population whose need for inpatient hospital services was not being met by reason of the coverage limitation, that it was "clear that reimbursement will be denied for a large number of medically needy indigents" (App. A at 16a). Based upon its interpretation of 42 C.F.R. §440.230(b), the Court ruled that the challenged hospital coverage limitation thus resulted in an unreasonable denial of hospital services to the Medicaid population as a whole (App. A at 16a).

In his dissenting opinion Justice Schreiber concluded that neither 42 U.S.C. 1396a(a)(13)(D) nor interpretive regulations promulgated by the Secretary of Health, Education and Welfare "requires the State to pay a hospital for inpatient hospital care when these services are no longer needed" (App. A at 20a). Additionally, he noted the Act's express deference in 42 U.S.C. §1396 to a State's fiscal constraints in establishing its Medical assistance program. Based upon this interpretation of governing federal law, the fact of HEW approval of the State plan and the undisputed and significant increase in State expenditures which would be required for extended coverage, Justice Schreiber concluded that the challenged limitation of inpatient hospital services was a reasonable one and consistent with federal law.

REASONS FOR GRANTING THE WRIT

The holding of the Court below that Title XIX of the Social Security Act prohibits a State's denial of inpatient hospital coverage in its medical assistance program for any necessary care provided by a hospital raises substantial questions of significance to Medicaid programs throughout the country and poses a conflict with the rulings of this Court and lower federal courts as well as interpretations of the scope of State discretion under Title XIX adopted by the Secretary of HEW which can only be resolved by an authoritative ruling by this Court.

This petition presents several related questions of substantial national importance regarding the scope of State discretion to fashion medical assistance programs in accordance with prevailing fiscal conditions within the State. More specifically, this matter requires consideration of the extent of State statutory obligation under federal law to fund necessary inpatient hospital services made available to Medicaid recipients. In that all States which have established medical assistance programs pursuant to Title XIX are obligated to provide coverage for inpatient hospital services, the decision below, which interprets the Social Security Act to require a medical assistance program far broader in coverage than that envisioned by Congress, necessarily will have profound implications for Medicaid programs throughout the country.

Additionally, this matter raises the precise issues left unresolved in *Beal* v. *Doe,* 432 U.S. 438, 444 (1977), namely the "serious statutory questions . . . presented if a State Medicaid plan excluded necessary medical treatment from its coverage . . .". As resolved by the Court below, notably without any review of the extensive legislative his-

tory of Title XIX of the Social Security Act and without the participation of the federal Department of Health, Education and Welfare, Title XIX must now be construed as requiring reimbursement of *all* inpatient hospital services provided to individuals who are in need of medical care and who cannot be removed from a hospital. In so concluding, the Court necessarily mandates coverage not only for individuals such as those herein who were awaiting placement in apartments or in lesser care facilities, but also those persons whose need for hospital care would extend beyond a durational limit established by a Medicaid program. See, e.g. *Virginia Hospital Association* v. *Kenley,* 427 F. Supp. 781 (E.D. Va. 1977); *Commonwealth of Pennsylvania Department of Public Welfare* v. *Temple University,* 21 Pa. Commw. Ct. 162, 343 A.2d 701 (Commw. Ct. 1975). Clearly hospitals treating patients whose need for acute level care exceeds the durational limit for reimbursement are faced with the same dilemma which confronted Monmouth Medical Center herein: namely the prospect of no reimbursement for "necessary care [which] has been rendered to an unavoidably retained patient." (App. A at 14a).

This conclusion however is in direct conflict with the regulations, interpretative statements, and legal position of the federal Department of Health, Education and Welfare which is responsible for the administration of the Title XIX programs. See, e.g., 42 C.F.R. § 440.230(b), *Virginia Hospital Association* v. *Kenley, supra,* at 785-786 and HEW Field Staff Information and Instruction Series: FY76-62 at p. 7 (January 21, 1976) quoted in *Kenley* at p. 786. Moreover, the Court's invalidation of the State's limitation wholly abrogates the action by the Secretary of HEW in approving New Jersey's State plan limitation. In light of the clear lack of any procedural mechanism for the State to have compelled HEW's participation in the appeal and the absence of any in-depth analysis by the Court below of the statutory language of Title XIX or its legislative history, and more significantly, any factual evidence proffered by the challenger of the limitation to rebut the necessary presumption of the reasonableness of the limitation, the Court's action below flies in the face of repeated concerns expressed by the Court that the judiciary be mindful that "the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong . . ." *New York Dept. of Soc. Services* v. *Dublino,* 413 U.S. 405, 421 (1973), quoting *Red Lion Broadcasting Co.* v. *F.C.C.,* 395 U.S. 367, 381 (1969).

In concluding that these very costly services must be reimbursed by the State, the Court below further ignored established principles governing construction of the Social Security Act. It is evident from the Court's decision in *Quern* v. *Mandley,* 436 U.S. 725 (1978) that language appearing in general purposes clauses of various chapters of the Social Security Act can only be construed as defining the parameters of the program for which federal funding will be made available, and not mandatory eligibility conditions imposed upon participating States. It necessarily would follow therefore in construing the appropriations section of Title XIX, 42 U.S.C. § 1396, that its reference to the appropriation of federally funding for "necessary medical services" can only reasonably be interpreted as establishing the types of services for which federal funding would be available. Contrary to these principles however the Court below has viewed the § 1396 language as establishing an absolute coverage requirement. By further defining the phrase as mandating payment even for care provided at a level which is no longer appropriate, the Court has rendered the Congressional

delegation of discretion to the State utterly without meaning.

Review by this Court is thus appropriate since the decision entered below presents very serious conflicts with prior decisions of this Court as well as lower Court decisions addressing the issue of the range of State discretion in establishing the parameters of public assistance programs. Moreover, the decision which construes the Social Security Act to require a medical assistance program far broader than that intended by Congress promises to undermine substantially the necessary flexibility a State must have to fashion such assistance programs in accordance with medical and fiscal priorities. Resolution of these questions is therefore vital in order to insure the uniform administration of State medical assistance programs in accordance with Congressional objectives as well as to reaffirm principles established in previous decisions of the Court.

A.

Certiorari should be granted to resolve the significant question expressly left open in *Beal* v. *Doe* as to state discretion under Title XIX to limit coverage for medically necessary services in mandated categories of health care.

This petition raises what has become an increasingly frequent issue before the Court and other federal and state courts: ascertainment of the proper interplay between federal mandate and State prerogative in a public assistance program developed and funded through cooperative federalism. The specific issue presented—State discretion to deny reimbursement for inpatient hospital services provided to individuals requiring a lesser level of medical care—poses the question, expressly left unresolved in *Beal* v. *Doe* as to State discretion to exclude non-elective medical treatment from coverage. The court below responding to the question in the negative, has held that irrespective of the appropriate level of care required by a Medicaid patient, where diligent hospital efforts have failed to effect placement in a lesser care facility, the State is required to assume the full costs of maintaining these patients at a hospital level of care. In concluding that the State cannot limit inpatient hospital Medicaid coverage based upon the appropriateness of the level of placement, the court below has misconstrued governing federal Medicaid coverage provisions, ignored the interpretation of these provisions advanced by the federal agency which administers the Medicaid program and utterly usurped the prerogative of States to fashion a medical assistance program in accordance with reasonably perceived needs of the Medicaid population. Because the court has proceeded in such utter disregard of federal judicial precedents and federal administrative interpretation and because the matter resolved will have profound implications as to the flexibility of State Medicaid programs' development of priorities in mandatory coverage areas, review by this Court is imperative.

In choosing to afford to certain groups of its needy citizens the benefits provided under the federally-assisted and State administered medical assistance program, New Jersey has agreed to reimburse providers of inpatient hospital services, for the "payment *of part* or all of the costs" of these services, 42 U.S.C. § 1396d(a) (emphasis supplied). See also 42 U.S.C. § 1396d(a)(1), 42 U.S.C. § 1396a(a)(13)(B). As is evident from the limiting language of 42 U.S.C. § 1396d(a) and the reference in 42 U.S.C. § 1396 to the State's provision of "medical assistance" "as far as practicable under the conditions in such

State," Congress clearly was not mandating comprehensive coverage of this category of care.

The limited federal goals are further apparent from the legislative history of the program. As originally enacted Title XIX would have required participating states to move toward, and eventually to furnish, "comprehensive care and services to substantially all individuals who [met] the plan's eligibility standard with respect to income and resources" by July 1, 1975. 42 U.S.C. § 1396b (e), as enacted by Social Security Amendments of 1965, Title XIX, § 1903(e), Pub. L. 89-97, 79 Stat. 286, 350. Recognizing the significant and increasing burden of Medicaid costs upon State finances, Congress, in 1972, enacted a number of amendments to Title XIX for the express purpose of affording states fiscal relief and additional administrative latitude. Included in these amendments was a provision which repealed section 1903(e). Social Security Amendments of 1972, Pub. L. 92-603, Title II § 230, 86 Stat. 1329 (1972). For similar reasons, Congress repealed section 1902(d), which barred State reduction of approved expenditures from one year to the next. By enacting and then repealing these sections, Congress made clear that Title XIX in its current form does not require comprehensive coverage even of mandatory services. Further, these legislative actions confirmed that diminishment of the fiscal burden of a State Medicaid program is a valid motive for reducing such coverage.

It is apparent thus from both the legislative history and language of Title XIX that federal law does not mandate the State's reimbursement of all reasonably necessary inpatient hospital services. Rather, as H.E.W. and the federal district court in *Virginia Hospital Association* v. *Kenley, supra,* at 785 concluded a State does have the discretion to define what mandatory services are "medically necessary" and to limit coverage accordingly. The sole limitation upon State discretion expressed in Title XIX is the requirement that the State plan "include reasonable standards . . . for determining the extent of medical assistance under the plan which . . . are consistent with the objectives" of Title XIX. 42 U.S.C. § 1396a (a)(17). Since Title XIX expressly recognizes as a legitimate concern the fiscal limitations of each State (see 42 U.S.C. § 1396) and noteably fails to define any minimal level of required coverage, the Secretary of HEW has interpreted the reasonableness standard to leave largely to State discretion the formulation of plans for adequate coverage. A State plan therefore can limit the amount and/or duration of coverage so long as services provided are "sufficient in amount, duration and scope to reasonably achieve its purpose." 42 C.F.R. §440.230(b). As further interpretated by the Secretary in the *Virginia Hospital Association* v. *Kenley* litigation, inpatient hospital coverage can be limited so as to bar the payment of medical assistance for medically necessary hospital services in individual cases so long as the limitation does not threaten the ability of the Medicaid population as a whole to obtain hospital care.*

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* Although the Court below concludes that New Jersey's limitation failed to satify this requirement, that conclusion was reached from an absolutely barren factual record. The Court does not dispute respondent's failure to produce any evidence demonstrating an inordinate denial of impatient hospital services effected by the regulation. Rather the Court makes the absolutely unwarranted and radical suggestion that irrespective of the showing by the State of a strong fiscal and policy interest in utilizing monies saved from the limitation for the provision of optional service coverage in other areas, it was the State's and not the respondent's burden to demonstrate why this presumptively reasonable action did not constitute

(Footnote continued on following page)

The correctness of Petitioners', HEW's and the *Kenley* court's reading of Title XIX as not requiring coverage of all non-elective medical services falling within mandated categories of care is further substantiated by the Court's ruling in *Quern* v. *Mandley, supra.* Therein the Court considered whether the definition of "emergency aid to needy families with children" set forth in 42 U.S.C. § 606(e) imposed mandatory conditions of eligibility for every State Emergency Assistance program. Concluding to the contrary, the Court noted that a literal implementation of public welfare programs as broadly defined in the general purposes clauses of the various Social Security Act chapters "would create . . . entirely open-ended program[s], not susceptible of meaningful fiscal or program-

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(Footnote continued from preceding page)

an unwarranted limitation of inpatient hospital services in general. Clearly, the imposition of such a burden of proof upon the State flies in the face of repeated pronouncements by this Court as to a challenger's obligation to rebut the presumption of validity of State action and to establish entitlement under a public assistance program. See, e.g., *Lavine* v. *Milne,* 424 U.S. 577 (1976). Beyond this and notwithstanding the absence of any statistical evidence in the record as to the percentage of the Medicaid inpatient hospital population affected by the State's policy and noteably without citation of any facts, the Court concludes that "[g]iven the widespread unavailability of skilled care beds, it is clear that reimbursement will be denied for a large number of medically needy indigents." (App. A at 16a). Thus, the Court's determination as to the unreasonableness of the State limitation of coverage is unsupported by any evidence whatsoever. Moreover, the Court's ruling accords insufficient deference to the strong State interest in fashioning its medical assistance program to the best of its ability and to the extent of limited available funds. See *Geduldig* v. *Aiello,* 417 U.S. 484, 494-496 (1974); *Jefferson* v. *Hackney,* 406 U.S. 535, 551 (1972). See generally Note, *State Restrictions on Medicaid Coverage of Medically Necessary Services,* 78 Colum. L. Rev. 1491 (1978).

matic control by the states." *Id.* at 746. A more reasonable Congressional objective the Court opined was the establishment through these provisions of permissible limits of federal spending, rather than the definition of mandatory coverage areas for participating States. *Id.* at 745. Consistent with these principles of construction the Court interpreted the language of 42 U.S.C. § 1397, the appropriations section for Title XX Social Services programs, whose declared purpose was to "encourag[e] each state, *as far as practicable under the conditions in that State* to furnish services directed at the goal of . . . achieving or maintaining economic self-support to prevent, reduce or eliminate dependency," (emphasis supplied) as an expression of Congressional intent to delegate to the States ultimate decision-making authority in establishing priorities within the constraints of federal funding limitations. *Id.* at 745.

Similarly, the lone appearance of the term "necessary medical services" in the almost identically worded appropriation section for the federal Medicaid statute (42 U.S.C. § 1396) cannot be viewed as imposing a mandatory requirement of coverage. As with the appropriation sections of Title XX and the Emergency Assistance definition, the use of the term "necessary medical services" simply specifies the type of services for which federal matching funds will be available. It does not, as has been decided below, establish the minimum limits of a participating State's mandatory service coverage. In accord, see *Preterm, Inc.* v. *Dukakis,* 591 F.2d 121, 124 (1st Cir.), *cert.* denied —— U.S. —— (1979).

Furthermore, even if States were found to have an obligation to fund all medically necessary services, there is the additional significant question of what is meant by

the term "necessary medical services." This issue is also squarely presented by the present case. Here, hospital level care was not medically required for the individuals involved; only medical services which could be provided at a lesser level of care at a nursing home or in the community were necessitated. Notwithstanding this fact, the Court below concluded that such care provided by the respondent constituted necessary medical services within the meaning of 42 U.S.C. §1396.

The elaborate policy arguments which the Court below constructs in an utter vacuum of analysis of the statutory language or legislative history of Title XIX only confirms the appropriateness of review by this Court. As has been previously shown, the decision entered below is inconsistent with the opinions of the Court, the express language and legislative history of applicable provisions of Title XIX of the Social Security Act as well as the interpretations of those provisions espoused by the federal agency responsible for supervising participating States' administration of the Medicaid program. Moreover, the Supreme Court of New Jersey's decision will effect a severe limitation upon the State's ability to pick and choose what services it deems essential for the Medicaid population. And finally, if the decision below is permitted to stand, and in the absence of any Federal approval of a lesser standard of payment, additional State Medicaid appropriations of almost $19,000,000 would be required in order to avoid staggering reductions in Medicaid services throughout the State. In view of these significant factors and the public importance of the issue presented, review by this Court is imperative.

B.

The Court's review of the issue of State discretion under Title XIX to determine whether a service is medically necessary and to deny coverage for necessary medical treatment within mandated coverage areas is imperative in order to resolve the conflicting interpretations of the statute by Federal and State judiciary and HEW.

The significance of the issue presented herein is apparent not only from this Court's comments in *Beal* v. *Doe* but from repeated and conflicting resolutions of the question emanating from State and Federal Courts. Thus, in *Virginia Hospital Association* v. *Kenley, supra,* in which the HEW Secretary was joined as a party, the Federal District Court for the Eastern District of Virginia adopted HEW's interpretation of Title XIX requirements and concluded that a State Medicaid program could exclude coverage for medically necessary inpatient hospital services (therein beyond a twenty-one (21) day limit) for a significant percentage (8%) of the Medicaid population. Similarly, in *Commonwealth of Pennsylvania Dept. of Public Welfare* v. *Temple University, supra,* the Court concluded that in the absence of any evidence to the contrary, a sixty (60) day limitation upon inpatient hospital service coverage was of sufficient duration to reasonably achieve the purpose of providing inpatient hospital care. The United States Court of Appeals for the First Circuit in *Preterm, Inc.* v. *Dukakis, supra,* presented an equally broad approach to the question of State discretion in its rejection of the lower Court's conclusions that a participating State must fund all medically necessary services within the mandated categories as determined by a physician. *Id.* at 124, 125, 131, and 134. This interpretation was expressly adopted by the United States Court of Appeals for the Seventh Circuit in *Zbaraz* v. *Quern,*

596 F.2d 196, 198 (7th Cir. 1979) in the context, as in *Preterm,* of a challenge to a Medicaid abortion limitation.

Contrary conclusions also have been reached by both federal and state courts. Thus, in *Roe* v. *Casey,* 464 F. Supp. 487, 500-502 (E.D. Pa. 1978) and *Right to Choose* v. *Byrne,* 165 N.J. Super. 443, 398 A.2d 587, 592 (Chan. Div. 1979), both involving challenges to Medicaid abortion funding restrictions, the courts interpreted 42 U.S.C. § 1396 and 42 C.F.R. § 449.10(a)(5)(1) as mandating State funding of all necessary medical services. Indeed, the *Roe* v. *Casey* court concluded, relying squarely upon *Beal* v. *Doe,* that State discretion in establishing the parameters of a medical assistance program extended only so far as to allow exclusion or limitation of unnecessary medical services. *Id.* at 501. Again, in *Rush* v. *Parham,* 440 F. Supp. 383 (N.D. Ga. 1977) app. pending *sub nom. Rush* v. *Poythress,* No. 77-2743 (5th Cir.), the Court in invalidating a ban on reimbursement for transsexual surgery, similarly relied upon the *Beal* decision in concluding that "Medicaid coverage is not optional or discretionary for necessary medical treatment of eligible recipients." *Id.* at 389. See also *G. B.* v. *Lackner,* 80 Cal. App. 3d 64, 145 Cal. Rptr. 555 (1978); *Doe* v. *Minnesota Department of Public Welfare,* 257 N.W. 2d 816 (Minn. 1977). Of particular note in the *Rush* v. *Parham* decision is the fact that the Court rejected the position of HEW, a defendant in the action, that the State limitation comported with federal requirements of sufficiency and reasonableness.*

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* Unlike the decisions noted above, in which State limitations of Medicaid coverage have been invalidated, the action taken by the Court below will require the expenditure of significant State and federal monies. Of further significance is the fact that the Court below has determined an issue of national importance and invalidated

(Footnote continued on following page)

It is apparent therefore that since the issuance of the *Beal* decision, over two years ago, State and federal courts throughout the country have repeatedly grappled with the significant question left open by that decision: the extent of State discretion to deny Medicaid coverage for medically necessary services. The many conflicting opinions rendered by these courts and particularly those in which HEW approved State plan amendments have been invalidated, has created great confusion nationally as to the terms of States' participation in the Medicaid program. The time is ripe therefore for the Court's consideration and determination of this question. A writ of certiorari should thus issue in order that the Court can resolve the question of State prerogative to define areas of coverage in a State Medicaid program for "medically necessary" services.

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action taken by the federal agency responsible for administration of the Medicaid program without benefit of any input by that agency. Certainly, a more complete development of the legal issue before this Court during which the views of HEW would be presented is desireable and would best protect the public interest. See *Rosado* v. *Wyman,* 397 U.S. 397, 406-407 (1970).

CONCLUSION

For the abovestated reasons, it is respectfully submitted that this petition for a writ of certiorari to the Supreme Court of New Jersey should be granted.

Respectfully submitted,

JOHN J. DEGNAN,
Attorney General of New Jersey,
Attorney for Petitioners, State of New Jersey; Ann Klein, Commissioner of the Department of Human Services of the State of New Jersey; and Thomas M. Russo, Director of the Division of Medical Assistance and Health Services of the State of New Jersey

APPENDIX A

Opinion of the Supreme Court of New Jersey

(Filed—June 18, 1979)

SUPREME COURT OF NEW JERSEY

A-129/130 SEPTEMBER TERM 1978

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Respondent-Cross-Appellant,

v.

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of Institutions and Agencies of the State of New Jersey; GERALD J. REILLY, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Appellants-Cross-Respondents.

Argued February 21, 1979—Decided June 18, 1979

On certification to the Superior Court, Appellate Division, whose opinion is reported at 158 N.J. Super. 241 (1978).

Appendix A

Ms. Andrea M. Silkowitz, Deputy Attorney General, argued the cause for appellants (*Mr. John J. Degnan,* Attorney General of New Jersey, attorney; *Mr. Stephen Skillman,* Assistant Attorney General, of counsel).

Mr. Frank R. Ciesla argued the cause for respondent (*Messrs. Giordano, Halleran and Crahay,* attorneys; *Mr. Ciesla* and *Mr. Phil H. Leone,* on the briefs).

The opinion of the Court was delivered by
PASHMAN, J.

The primary issue presented in this case is whether a State may, consistent with the Federal Medicaid Act, 42 U.S.C. §1396 *et seq.*, and its accompanying regulations, 42 C.F.R. §430 *et seq.* (1978), deny reimbursement to a hospital for medically necessary services rendered to an eligible patient who can be adequately treated in a less intensive care facility but who, through no fault of the hospital, cannot be suitably placed. Specifically, we must determine the validity, as applied to the facts of this case, of a State regulation which denies recompense to a hospital for inpatient services provided to a Medicaid recipient awaiting placement in a skilled nursing home or intermediate care facility. We are further asked to consider whether the review process utilized by the Division of Medical Assistance and Health Services (Division) in order to determine the merits of a hospital's objections concerning denials of reimbursement comports with the requirements of procedural due process.

For the reasons given below, we conclude that the hearing procedure survives constitutional scrutiny, but that nonetheless the challenged reimbursement regulation is

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inconsistent with the Federal Act and hence invalid under the Supremacy Clause of the United States Constitution. U. S. Const., Art. 6.

Medicaid is a program whose principal aim is that of "enabling each State, as far as practicable under the conditions in such State, to furnish * * * medical assistance [to] individuals whose income and resources are insufficient to meet the costs of necessary medical services * * *." 42 U.S.C. §1396. In order to achieve this goal, a complex cost-sharing mechanism has been constructed providing for partial federal funding of medical services rendered to the indigent.[1]

The Medicaid Act represents an exercise in what has been termed "cooperative federalism." Note, "State Restrictions on Medicaid Coverage of Medically Necessary Services," 78 Colum.L.Rev. 1491, 1491 (1978). The program is primarily administered by the State, subject to federal guidelines and constraints. Each participating State is required to adopt a plan, which must be approved by the Secretary of the Department of Health, Education & Welfare (HEW), covering in detail the services to be rendered. 42 U.S.C. §§1396, 1396a(a). The plan must provide for five general categories of medical assistance and may include others.[2] 42 U.S.C. §1396a(a)(13)(B). Rein-

[1] The percentage of Medicaid expenses defrayed by the federal government ranges from 50% to 83⅓%. *See* 42 U.S.C. §§1396b; 1396d(b); 1301(a)(8)(B). New Jersey's federal share amounts to 50%.

[2] The mandatory coverage areas are: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and

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bursement must be provided for "the reasonable cost of inpatient cost of inpatient hospital services," *id.* §1396a (a)(13)(D), and "skilled nursing facility and intermediate care facility services * * * on a reasonable cost related basis * * *." *Id.* §1396a(a)(13)(E).

Plaintiff Monmouth Medical Center (Monmouth), a nonprofit hospital situated in Long Branch, has contracted with the State to be a provider of medical services to eligible recipients pursuant to the State Medicaid Program. N.J.S.A. 30:4D-1 *et seq.* Under this agreement Monmouth is obligated to provide medically necessary inpatient services to the "categorically needy." This group consists of

> . . . all individuals receiving aid or assistance under any plan of the State approved under subchapter I [Old Age Assistance], X [Aid to the Blind], XIV [Aid to the Disabled], or XVI [Supplemental Security Income], or part A of subchapter IV [Aid to Families with Dependent Children] of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter

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x-ray services; (4) skilled nursing facilities, early and periodic screening, and diagnosis and family planning services; and (5) physicians services. 42 U.S.C. §1396d(a)(1-5). Optional coverage categories include: (1) home health care services; (2) private duty nursing services; (3) clinical services; (4) dental services; (5) physical therapy; and (6) intermediate care facility services. 42 U.S.C. §1396d(a)(7)-(11), (15).

> XVI of this chapter [.] [42 U.S.C. §1396a(a)(10)(A)][3]

In return, Monmouth is entitled to reimbursement by the State for certain expenses incurred in treating these patients.

The present controversy originated when Prudential Insurance Company of America, an underwriter of the State's program,[4] denied in part three reimbursement claims submitted by Monmouth.[5] Pursuant to N.J.S.A. 30:4D-7(f) and N.J.A.C. 10:49-1.16, Monmouth requested a "fair hearing" before the Division to challenge the validity of Prudential's actions. On August 13, 1976 a consolidated proceeding was held before a Division Hearing Officer.

The first reimbursement claim involved services rendered to one Luther Townsend, a 55-year-old male who was hospitalized from April 7 to May 28, 1975 due to a fractured hip. Dr. James Gardam, Prudential's repre-

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[3] State plans must provide for the rendition of medical assistance to this group. Optional coverage may be extended to the "medically needy"—those who do not qualify for public assistance yet lack sufficient "income and resources to meet the costs of necessary medical and remedial care and services. * * *" 42 U.S.C. §1396a(a)(10)(C). New Jersey has chosen to give Medicaid relief only to the "categorically needy."

[4] Statutory authorization for such "fiscal intermediaries" is found in N.J.S.A. 30:4D-8. Rules governing their selection appear at N.J.S.A. 30:4D-9 through -11.

[5] A fourth claim was also denied, but it is not involved in this appeal and hence will not be discussed.

sentative, testified that as of April 23, 1975 the medical charts indicated that Mr. Townsend was convalescing satisfactorily. Although Prudential agreed that Townsend's condition necessitated physiotherapy and thus skilled nursing services, it contended that after May 8, 1975 there was no medical need for hospitalization. Prudential therefore denied reimbursement for services rendered after May 8 on the basis that less intensive—and less expensive—care was feasible.

Dr. James Kirby, Chairman of the Monmouth Medical Center Utilization Review Committee, agreed with Dr. Gardam that Townsend could have been adequately treated in a lesser care facility after May 8. He asserted, however, that Monmouth had been unable to place Mr. Townsend in a suitable institution and that the hospital would have been negligent had it merely released the patient to fend for himself.

Mrs. Cunningham, the Coordinator of Social Services at Monmouth, testified that beginning April 9, 1975 attempts were made to place Mr. Townsend in a nursing home or intermediate care facility. The hospital canvassed all such facilities in Monmouth and Ocean Counties on a daily basis. It was not until May 28 that a bed became available and therefore Townsend was not discharged until that date. Mrs. Cunningham further explained that the hospital did not contact institutions in other counties because it was already aware that they had no available space.

The second case involved Madeline Papikas, a 47-year-old female admitted on April 9, 1974 due to kidney and liver failures. The seriousness of her condition necessitated a lengthy hospital stay. As of September 1, 1974,

however, her medical chart revealed that she was sufficiently stabilized for transfer to a lesser care facility. Nevertheless, due to an unfortunate morass of bureaucratic red tape, Monmouth was unable to obtain a Medicaid number for Mrs. Papikas despite diligent efforts on its part.[6] Without such a number, no nursing home would accept her as a patient. By the time a number was finally procured, December 5, 1974, nursing home care was no longer necessary. Accordingly, Monmouth's Social Services Unit obtained an apartment for Mrs. Papikas and on December 10, 1974 she was discharged.

Both sides agreed that Mrs. Papikas needed medical attention even after September 1—the date after which Prudential refused to reimburse Monmouth—but that nursing home care would have been adequate. They further stipulated that it would have been negligent for Monmouth to have merely released her at that time.

The final case was that of James Rempkowski who was hospitalized from November 23, 1975 through March 9, 1976 due to a cardiac arrest and resultant brain damage. Although a lengthy period of hospitalization was required, the parties agreed that as of January 13, 1976 intensive care was no longer medically necessary. It was also agreed, however, that skilled nursing home facilities were mandated and that discharge of the patient—as opposed to transfer to a nursing home—would have amounted to negligence on the hospital's part.

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[6] The record reveals that local, state and federal agencies were all approached in an effort to expedite matters. Apparently the difficulty arose because the agencies could not obtain an address for Mrs. Papikas, her landlord having rented out her room after she was admitted to the hospital.

Appendix A

Mrs. Cunningham testified that the failure to transfer Rempkowski was due to difficulties encountered in obtaining a Medicaid number for the patient. Although a Supplemental Security Income application was filled out on December 4, 1975, and despite hospital attempts to expedite matters, Rempkowski's Medicaid number was not received until February 19, 1976. At that time, his name had already been placed on nursing home waiting lists. Not until March 8, 1976 was Monmouth notified, by the Bayview Convalescent Center, that a bed was available. Mr. Rempkowski was transferred the following day.

By report dated October 28, 1976, the hearing examiner recommended in all three cases that the hospital be fully reimbursed for the period denied by Prudential. In each case he found that Monmouth had acted in good faith and that "special circumstances" had prevented the discharge or transfer of the patient.

The Director of the Division, relying upon sections 202 and 202.9 of the Hospital Services Manual, *see* N.J.A.C. 10:52-1.2(b), 10:52-1.3(a)(18), modified the Hearing Officer's determinations. Those sections provide in part:

> 202. Non-Covered Inpatient Hospital Services
>
> Benefits are not payable for any services rendered or items dispensed or furnished in connection with:
>
> 202.9 *Services Rendered After Day Medically Necessary*
>
> Inpatient hospital services rendered after the day it is medically necessary, except when *special circumstances* prevent the discharge or transfer of the patient.

Appendix A

> Note: The Contractors may reimburse a hosptal up to 12 calendar days following the period established as being medically necessary if special circumstances (social necessity) prevent the discharge or transfer of the patient to his/her home or sheltered boarding home and the hospital has taken effective action to stimulate placement of the patient.
>
> • • •
>
> Payment for Special Circumstances (Social Necessity) is specifically precluded for:
>
> a. *Patients awaiting placement in a Skilled Nursing Facilty or Intermediate Care Facility.*
>
> b. Patients for whom a claim has been denied for lack of medical necessity.
>
> c. Patients who were not eligible recipients of the date of admission. (emphasis supplied)

Pursuant to the above regulation, the Director denied reimbursement for services rendered during periods in which a patient was retained due to unavailability of beds in lesser care facilities. He concluded, however, that "special circumstances" did exist for periods during which discharge was not forthcoming because of agency delay regarding the furnishing of patients with Medicaid numbers. Hence, reimbursement was allowed for such circumstances.

Accordingly, the Director made the following rulings. With regard to Luther Townsend, he denied payment for the entire period in question. The Hearing Officer's recommendation as to Madeline Papikas was modified so as to

provide payment only up to and including December 5, 1974—the day on which Medicaid eligibility had been established.[7] Reimbursement with respect to Rempkowski was limited to services rendered before February 20, 1976, the date on which his Medicaid number arrived. The Director thus denied the hospital's claim for reimbursement in all three cases for services rendered while the patients were "awaiting nursing home placement."

On March 8, 1977 Monmouth filed with the Appellate Division an appeal from those portions of the Director's decision which denied reimbursement. Named as defendants were the State, Commissioner Ann Klein, and Director Gerald J. Reilly (since replaced by Acting Director Thomas A. Russo). Monmouth also challenged the adequacy of the review procedure.

The Appellate Division, in a unanimous opinion by Judge Matthews, reversed the Director's determination. *Monmouth Medical Center* v. *State*, 158 N.J. Super. 241 (App. Div. 1978). It held that the Director had impermissibly conditioned reimbursement upon the type of facility in which care was provided rather than upon the necessity for the services rendered. *Id.* at 247. The appellate judges ruled that by foreclosing the Director's discretion to grant reimbursement where placement in a lesser facility was not possible, the regulation conflicted with the Federal Act. *Id.* at 249, 254. Accordingly, the court ordered that Monmouth be reimbursed in full for all services provided to the three patients. Finally, the Appellate Division rejected Monmouth's claim that a hearing was required before reimbursement could be denied, instead holding that a post-denial fair hearing was constitutionally adequate.

[7] The Appellate Division stated that reimbursement was rejected beginning September 1, 1975. *Monmouth Medical Center* v. *State*, 158 N.J. Super. 241, 246 (App.Div. 1978). In this respect it was mistaken.

On July 11, 1978 we granted the State's petition for certification. 77 N.J. 506 (1978). Monmouth, pursuant to R. 2:3-4, filed a cross-appeal as of right with respect to the issue of procedural due process. We now affirm.

I

The parties' contentions with respect to the alleged conflict between the State regulation and the Federal Medicaid Act may be briefly summarized. Monmouth notes that the goal of the Act, set forth in its preamble, is to furnish medical assistance to those who cannot afford the costs of "necessary" medical treatment. See 42 U.S.C.A. 1396. The hospital further emphasizes that 42 C.F.R. §440.230(b) (1978) requires State plans to provide services "sufficient in amount, duration and scope to reasonably achieve [their] purpose," and thus in its view mandates that the State reimburse hospitals for any services rendered which are "reasonable and necessary for a particular patient's health." Therefore, it argues, where an eligibile patient can neither be released nor placed in a suitable lesser care facility, the hospital must continue to treat him and is entitled to reimbursement therefor.

The State, on the other hand, denies that it must reimburse hospitals for all expenses required in treating an individual patient. Rather, it contends that as long as the needs of the Medicaid population *as a whole* are reasonably met, states are given great flexibility in tailoring their plans to suit their particular financial capabilities. The State emphasizes that the preamble, cited by

Monmouth, requires the provision of assistance only insofar as is practicable under the conditions extant in the particular state. Moreover, it asserts that 42 C.F.R. §440.230(b)(1978), also relied upon by the hospital, mandates only that limitations upon the scope and during of services be reasonable as measured by Medicaid patients as a group. The instant regulation is defended as saving the State substantial monetary sums and discouraging misutilization of hospital facilities.

Courts in other jurisdictions have divided upon the issue of whether a state must provide reimbursement for all medically necessary inpatient services provided each individual patient. *Compare Rush* v. *Parham,* 440 F.Supp. 383 (N.D. Ga. 1977) *with Virginia Hospital Ass'n* v. *Kenley,* 427 F.Supp. 781 (E.D. Va. 1977). We, however, find it unnecessary to join that particular fray inasmuch as we conclude that the State regulation here as issue is unreasonable and hence invalid even under the State's interpretation of federal requirements.

In order to assess the validity of the regulation, it is necessary to understand certain aspects of the State system of Medicaid reimbursement. Hospitals contract with the State to provide medical services to the indigent. Under this agreement, hospitals which have provided such services to Medicaid eligible patients may file for reimbursement from the State. Reimbursement is at a flat *per diem* rate irrespective of the level of care rendered or the actual costs incurred The State also reimburses skilled nursing homes and intermediate care facilities for reasonable expenditures made with respect to Medicaid recipients. Inasmuch as such facilities render less intensive services than do hospitals, however, their *per diem* reimbursement rate is considerably lower.

Due to the significant gap between hospital reimbursement rates and those received by less intensive care centers, the State has a substantial interest in encouraging use of the least expensive care facility medically practicable. Consequently, it has designed its reimbursement system so as to provide contracting hospitals with a strong disincentive to retaining Medicaid patients beyond the time when such intensive care is medically necessary.

We do not quarrel with the State's goal. Saving tax dollars and preventing misutilization of facilities are commendable aims. The instant regulation, however, paints with too broad a brush. It denies reimbursement not only to those hospitals which fail to use due diligence in placing patients in lesser care facilities, but also to those who, through no fault of their own, cannot find an opening in a suitable facility. In the latter case the hospital is penalized not because of its own laxity but, rather, solely because of circumstances beyond its control. *See Commonwealth Dept. of Pub. Welfare* v. *Temple U.,* 343 A.2d 701 (Pa. Cmwlth. 1975).[8]

We do not dispute the propriety of requiring the hospital to bear the burden of clearly demonstrating that it took all reasonable steps possible to place its patient. Nevertheless, in order not to transcend the Federal Act, the Division must exercise discretion so as to allow re-

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[8] In this respect we note that the Director does allow reimbursement when the reason why the patient could not be placed was the fault of a social welfare agency. Other courts have deemed such situations to be analogous to that where external conditions—such as lack of beds—prevented placement. *See St. Christopher's Hosp. for Children* v. *Commonwealth, Dept. of Pub. Welf.,* 372 A.2d 504 (Pa. Cmwlth. 1977).

imbursement where medically necessary care has been rendered to an unavoidably retained patient.

We realize that our holding does result in the State and federal governments being required to pay for the overutilization—as opposed to misutilization—of facilities. That is, the State will have to provide reimbursement at a higher rate for patients who are being retained in more intensive care centers than is medically necessary. The federal government will, in turn, be compelled to increase the amount which it expends in recompensing the State for half of its Medicaid expenses.[9] Although this consideration is not to be taken lightly, we conclude that for several reasons it is not controlling here.

First, we note that the obvious equitable solution would be to reimburse hospitals in such circumstances at a rate commensurate with that of the lesser care facility which could provide the needed services. Indeed, at oral argument the State admitted that it had requested HEW approval for such a repayment scheme. Inasmuch as states are permitted to reimburse participating hospitals at the reasonable—as opposed to the actual—cost of services rendered, we see no reason why the proposed plan cannot be implemented. *See, e.g.,* 42 U.S.C. §1396a(a)(13)(D); 42 C.F.R. 447.261(a)(1978); *Massachusetts Gen'l Hosp.* v. *Weiner,* 569 F.2d 1156 (1st Cir. 1978).

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[9] Our dissenting colleague intimates that the Secretary of HEW might decide not to reimburse the State for its share of expenses incurred in implementing this decision. Even assuming that HEW can refuse payment for expenses found to be mandated by the federal act, we were informed at oral argument that the regional office of HEW has already agreed to pay its half of any required costs. Thus, the burden of complying with this opinion will be equally shared by State and federal governments.

Further, the main obstacle to placing Medicaid patients is the critical statewide shortage of Medicaid-available beds in skilled care facilities. The State, however, is not powerless to alleviate that condition. It can both facilitate the construction of new health centers—as well as the expansion of existing institutions—and may encourage such facilities to make a greater number of spaces available to Medicaid recipients.[10] The State's failure to remedy the nursing home shortage cannot now be used to justify penalizing hospitals which exercise due diligence in placing their patients.

In addition to the above considerations, we cannot ignore the real impact upon the public of denying reimbursement. To the extent that a hospital is not recompensed for services rendered, it will have to absorb the costs itself.[11] This in turn will compel the hospital to pass on these unreimbursed costs to the non-indigent persons who utilize its facilities. Thus, the costs of providing for the indigent will be borne solely by those unfortunate enough to require hospital care, rather than being spread among State and national taxpayers. In our opinion, it is more just and equitable to spread the costs.

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[10] We note that our Appellate Division has recently held that the Commissioner of Health may, as a condition of licensure, require Medicaid-eligible health care facilities to allocate a "reasonable number" of beds to the care of indigents. *New Jersey Ass'n of Health Care Facilities* v. *Finley,* N.J. Super. (App.Div. 1979).

[11] It is true that the hospital may attempt to recoup such expenditures from the indigents to whom the services were provided. However, inasmuch as such people are, by definition, poor, the hospital is unlikely to recover any considerable amounts.

Finally, even absent the considerations explicated above, we are not convinced that the regulation at issue adequately provides for the needs of the Medicaid population as a whole. Given the widespread unavailability of skilled care beds, it is clear that reimbursement will be denied for a large number of medically needy indigents. Thus, this case is distinguishable from *Virginia Hosp. Ass'n* v. *Kenley, supra,* which upheld a 21-day limitation upon reimbursement for inpatient services provided to a particular Medicaid recipient. There the court explicitly found that the time period allowed was sufficient to fully meet the needs of 92% of all hospitalized Medicaid eligible patients. 427 F.Supp. at 786. Here, no such showing was made. Hence, the *Kenley* case, even assuming its validity, is of little applicability.

For the foregoing reasons, we conclude that under the circumstances presented the regulation at issue is unreasonable. Therefore, it is in clear conflict with federal requirements and invalid under the Supremacy Clause of the United States Constitution.

II

Having concluded that hospitals which have diligently endeavored but, through no fault of their own, are unable to place their patients in less intensive medical care facilities are entitled to reimbursement, the question remains whether Monmouth is so entitled. That is, we must decide whether Monmouth exercised the requisite diligence in attempting to place the three patients.

Our task in this regard is made difficult by the meagerness of the record. Except as relating to the case of

Luther Townsend, the evidence presented at the hearing was scanty and the hearing officer's findings phrased primarily in conclusory terms such as "good faith" and "special circumstances." Moreover, the Director, because he believed that payments were proscribed by the regulation, did not pass judgment upon the sufficiency of the hospital's efforts. Ordinarily, the appropriate action in such a case would be to remand the matter to the Division so that it could render its assessment and hold additional hearings, if necessary. However, due to the already long period of time that has elapsed since the hearing was conducted as well as the relatively small sums involved, we will decide the issues at the present juncture.

We conclude that the hospital is entitled to be fully reimbursed. In light of the known shortage of available beds and the evidence presented, the hearing officer's conclusion that the hospital acted in good faith and that special circumstances were present is not unreasonable.

We wish to emphasize that this limited finding should not be taken as setting any standard to which hospitals may in the future comply and be *per se* entitled to reimbursement. Rather, it merely represents the limitations of appellate review. Thus, the Director is free to apply his expertise to future cases and may specify in detail the precise steps which a hospital must take in placing patients. Such regulations, if reasonable, represent a valid attempt to prevent unnecessary overutilization.

Appendix A

III

Monmouth's contention that it is constitutionally entitled to a hearing *prior* to denial of reimbursment is rejected substantially for the reasons expressed by the Appellate Division. *Monmouth Medica Center* v. *State, supra,* 158 N.J. Super. at 254-256. At oral argument it appeared that the gravamen of the hospital's complaint was not truly the necessity for a pre-denial hearing, but rather the allegedly inordinate delay involved in obtaining post-denial review. This issue cannot be resolved on the basis of the record before us. We note, however, that hospitals have both a constitutional right and a statutory right under N.J.S.A. 30:4D-7(f) to a fair hearing within a reasonable time.

For the foregoing reasons, Monmouth is entitled to reimbursement for those periods denied by the Director. The judgment of the Appellate Division is affirmed.

Schreiber, J., dissenting.

New Jersey's receipt of federal funds to assist it in providing medical services and care for eligible persons in hospitals and nursing home facilities depends upon the existence of a state plan which must satisfy the federal requirements and be approved by the Secretary of Health, Education and Welfare (HEW). New Jersey's plan does satisfy those requirements and has been approved by the Secretary.

Appendix A

The federal Medicaid statute states that federal funds will be available to assist states in furnishing medical assistance for for certain eligible persons. The act provides that

> [f]or the purpose of enabling each State, *as far as practicable under the conditions in such State,* to furnish (1) medical assistance * * * and (2) rehabilitation and other services * * *, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education and Welfare, State plans for medical assistance. (42 U.S.C.A. § 1396; emphasis supplied)

It is important to recognize that in the first instance funding for services may be fixed by the state to the extent it deems practicable. This has been construed to mean, *inter alia,* financially feasible. As one commentator recently stated:

> Thus, while section 1396 establishes that one of Medicaid's objectives is to provide necessary medical services, it also reflects a congressional intent that each state have the freedom to tailor programs that are responsive to the fiscal conditions prevalent in that state. [Note, "State Restrictions on Medicaid Coverage of Medically Necessary Services," 78 Colum. L. Rev. 1491, 1499 (1978)]

The New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 *et seq.,* was enacted to enable the

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State to obtain the benefits provided by the federal law. The Division of Medical Assistance and Health Services in the Department of Institutions and Agencies has been charged with implementing and administering a program of medical assistance to do whatever is "necessary to secure for the State of New Jersey the maximum Federal participation that is available with respect to a program of medical assistance, *consistent with fiscal responsibility and within the limits of funds available for any fiscal year* * * *." N.J.S.A. 30:4D-7 (emphasis supplied). Authorizaiton was granted to promulgate rules and regulations to carry out that intent, N.J.S.A. 30:4D-7, as well as to provide the Secretary of HEW with the State's plan, N.J.S.A. 30:4D-7(a).

There is nothing in the federal law, including HEW regulations, which requires the State to pay a hospital for inpatient hospital care when those services are no longer needed. The federal act specifies the required content of a state medical assistance plan, including the "payment of the reasonable cost of inpatient services, provided under the plan * * *." 42 U.S.C.A. § 1396a(a)(13)(D). The Secretary's regulations in turn require that the amount and duration of each medical and remedial service provided be sufficient "to reasonably achieve its purpose." 42 C.F.R. § 440.230(b) (1978). This regulation does not require that the plan *must* include payment for inpatient hospital care when it is no longer needed.

Superimposed upon the care requirements are the fiscal restraints which a state may observe. Thus, a state plan which limited inpatient hospital care to a 21-day maximum period because of fiscal considerations has been upheld. *Virginia Hospital Ass'n* v. *Kenley,* 427 F. Supp. 781 (E.D. Va. 1977). The State is not required to pay for all reasonably necessary inpatient hospital services, but may limit coverage because of financial conditions. See *District of Columbia Podiary Soc'y* v. *District of Columbia,* 407 F. Supp. 1259, 1263-1264 (D.D.C. 1975) (recognizing that fiscal considerations play a legitimate role in a state's determination of what medical services to provide).

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Here, the State's reason for not reimbursing hospitals for inpatient care for those who no longer need that care is a financial one. In an affidavit filed in these proceedings the Commissioner estimated that compliance with the majority's decision would increase the yearly expenditures by more than $37,000,000. The State might expect a reimbursement from the federal government of approximately 50% of that amount, provided that the Secretary of HEW finds the Court's modification of the current program acceptable.[1]

Although the State has proposed to amend its plan so that hospitals which may be forced to keep patients because of the unavailability of nursing home facilities may be reimbursed at the lower rate paid to nursing homes, this amendment has not been approved by the Secretary of HEW. Such approval would appear to be necessary since the proposed scheme will result in a change in the "method and standards" for reimbursement of hospitals for inpatient services. See 42 C.F.R. § 447.261(a) (1978). See *Hospital Ass'n of New York State, Inc.* v. *Toia,* 73 F.R.D. 565, 567 (S.D.N.Y. 1976), vacated on other grounds

[1] At the oral argument the Deputy Attorney General stated that the regional office of HEW, not the Secretary, had indicated that if payment were ordered in this proceeding the federal government would share in this cost. The Secretary was not a party in these proceedings.

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435 F. Supp. 819 (S.D.N.Y. 1977), aff'd 577 F.2d 790 (2d Cir. 1978).

Authority to decide whether any modification of the State's plan is appropriate, particularly when the change may have a substantial fiscal impact, has been delegated by Congress and the State Legislature to others. The plan as approved by the Secretary of HEW and implemented by the Commissioner of the Department of Institutions and Agencies was within their respective delegated authority. See Note, *supra*, 78 Colum. L. Rev. at 1506, criticizing the Appellate Division decision in this case. As stated by the United States Supreme Court:

> [W]e must be mindful that "the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong * * *." [*New York Dept. of Soc. Services* v. *Dublino*, 413 U.S. 405, 421, 93 S. Ct. 2507, ——, 37 L. Ed. 2d 688, 699 (1973), quoting *Red Lion Broadcasting Co.* v. *F.C.C.*, 395 U.S. 367, 381, 89 S. Ct. 1794, ——, 23 L. Ed. 2d 371, 384 (1969)]

I would reverse and enter judgment for the State.

APPENDIX B

Opinion of the Superior Court of New Jersey, Appellate Division

(Filed—March 27, 1978)

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION

A-2312-76

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Appellant,

v.

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of Institutions and Agencies of the State of New Jersey; GERALD J. REILLY, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Respondents.

Argued December 14, 1977—Decided March 27, 1978

Before Judges Matthews, Crane and Antell.

On appeal from the Division of Medical Assistance and Health Services.

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Mr. Frank R. Ciesla argued the cause for appellant (Messrs. Giordano, Halleran & Crahay, attorneys).

Ms. Andrea M. Silkowitz, Deputy Attorney General, argued the cause for respondents (Mr. William F. Hyland, Attorney General of New Jersey, attorney; Mr. Stephen Skillman, Assistant Attorney General, of counsel).

The opinion of the court was delivered by
MATTHEWS, P.J.A.D.

Monmouth Medical Center (claimant) a provider of inpatient hospital services under the New Jersey Medical Assistance and Health Services Program (Medicaid), N.J. S.A. 30:4D-1 *et seq.*, appeals from a final decision of the Director of the Division of Medical Assistance and Health Services modifying in part the decision of the program fiscal intermediary, Prudential Insurance Company of America (Prudential), to deny in part the payment of claims submitted by claimant for services provided to three Medicaid recipients, Luther Townsend, James Remkowski and Madeline B. Papikas. (A fourth recipient's claim is not challenged on this appeal).

Monmouth Medical Center is a non-profit hospital located in Long Branch, Monmouth County. It entered into an agreement with the former Department of Institutions and Agencies to provide medically necessary inpatient services to persons deemed eligible to receive benefits under the Medicaid program, and agreed to "abide by the rules and regulations" of the program. N.J.A.C. 10:52-1.1(1)(iv). The controversy before us arises because of the Director's insistence that under the agreement claimant is bound by the express provisions of N.J.A.C. 10:52-1.2(a)(18) (Note), (b)(1), which literally preclude reimbursement for inpatient hospital services provided while a patient awaits placement in a skilled nursing facility or intermediate care facility.

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Originally, Prudential, as agent of the Department of Institutions and Agencies for the purposes of reviewing claims submitted by providers under the Medicaid Program, denied coverage for portions of the periods during which the named individuals were patients and receiving care at the Monmouth Medical Center. In each instance, claimant requested a fair hearing before the Division. Thereafter, a full hearing on each case was held before a hearing officer who recommended the claimant be reimbursed for the payment periods which had been denied by Prudential. The Director rejected the hearing officer's recommendation in the Townsend case and denied payment for the period in question, and he modified the hearing officer's recommendations in the Papikas and Rempkowski cases, allowing payments for part of the disputed periods.

The following constitute brief summaries of the basic facts surrounding the hospitalization of the three patients whose cases precipitated these proceedings.

Luther Townsend, a medicaid recipient with a history of alcoholism and chronic epilepsy, was hospitalized from April 7, 1975 to May 28, 1975 with a broken hip. Surgery was performed on April 15, 1975. Sometime after April 9, 1975 claimant's Social Services worker began a search for a nursing home that would accept a patient with Mr. Townsend's disabilities and whose only source of funds was Medicaid. On May 28, 1975 a bed was finally found in a home in Cliffwood Beach, Monmouth County. It is undisputed that there was no hesitation or delay on the

part of the attending physician, or the Social Services Department in placing Mr. Townsend in any nursing home that would accept him. However, Prudential and the Director determined that further inpatient hospital stay was not medically necessary beyond May 8, 1975. In addition, it was the Director's decision that, since §202.9 of the Hospital Services Manual (N.J.A.C. 10:52-1.2(a) 18 Note, (b)1), provides that payment for special circumstances is specifically precluded for patients awaiting placement in a skilled nursing facility or intermediate care facility, the denial of payments to Mr. Townsend was justified, even though through no fault of his own or that of his provider he was not able to be discharged until May 29, 1975. It is conceded by the Division that Mr. Townsend required medical attention beyond May 8, 1975 but that such attention should have been given in a lesser care facility. In reinstating Prudential's decision, the Director denied claimant reimbursement for 19 days at a cost of $2,827.39.

In the case of Madeline Papikas, hospital services were rendered from June 1, 1974 to December 10, 1974. The Director determined that her inpatient hospital stay was not medically necessary beyond September 1, 1974. Accordingly, 99 days of hospitalization were rejected. Mrs. Papikas' case involved a series of bureaucratic delays by government agencies in approving her medicaid coverage which made it initially impossible to place her in a lower level care facility. By the time the delays were resolved on December 5, 1974, the patient had recovered to the point where she could be released. It is conceded that Mrs. Papikas required medical attention and that Monmouth Medical Center was the only facility then available to render the needed care.

The period of time involved in the case of James Rempkowski extended from November 23, 1975 to March 9, 1976. The patient required intensive medical care from November 11, to January 13. The Utilization Review Committee in essence agreed with Prudential's determination that there was a decrease in the medical necessity for acute bed care at that time. However, as in the Papikas case, there were again eligibility problems. Eligibility was cleared on February 19, 1976, and the patient's Medicaid number was received on February 21, 1976. The patient was discharged and admitted to Bayview Convalescent Center on March 9, 1976, as he had already been placed on the waiting list. Prudential denied payment for January 13, 1976 to March 9, 1976. The Director again modified the hearing officer's recommendation and allowed payment up to and including February 19, 1976, as the effective date of eligibility. However, he determined that no payment be made beyond the above date because Regulation 202.9, referred to above, precluded payment for patients awaiting nursing home placement.

In each case the Director found that medical necessity is based on *where* needed care is obtained and not on *whether* the care is in fact necessary for the well-being of the patient.

It is undisputed that it would have been negligent for claimant to have discharged any of these patients to anything but a skilled nursing care facility on the respective dates that hospital care was no longer required.

Appendix B

I

Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq.*, establishes a Medical Assistance Program under which participating states may provide federally funded medical assistance to needy persons. Title XIX establishes two groups of needy persons: (1) the "categorically" needy, which includes needy persons with dependent children, and the aged, blind, and disabled, 42 U.S.C. §1396a (a)(10)(A), and (2) the "medically" needy, which includes persons financially ineligible for AFDC or SSI benefits, 42 U.S.C. §1396a(a)(10)(C). Participating states are not required to extend medicaid coverage to the "medically" needy, and New Jersey has chosen not to do so (N.J.S.A. 30:4D-3(f)). The federal statute requires participating states to provide qualified individuals with financial assistance in five general categories of medical treatment (including inpatient hospital services). 42 U.S.C. §§ 1396a(a)(13)(B), 1396a(a)(1)-(5).

Although Title XIX does not require states to provide funding for all medical treatment falling within the five categories, it does require that state Medicaid plans establish "reasonable standards * * * for determining * * * the extent of medical assistance under the plan which * * * are consistent with the objectives of [Title XIX]." 42 U.S.C. §1396a(a)(17). *Beal* v. *Doe,* —— U.S. ——, 97 S.Ct. 2366, 2369; 53 L.Ed. 2d 464, 470 (1977).

Sections 202 and 202.9 of the Hospital Services Manual, derived from N.J.A.C. 10:52-1.2(a)(18) Note, (b)(1) state:

> 202. *Non-Covered Inpatient Services*
>
> Benefits are not payable for any services rendered or items dispensed or furnished in connection with:
>
> * * *

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> 202.9. *Services Rendered After Day Medically Necessary*
>
> Inpatient hospital services rendered after the day it is medically necessary, except when special circumstances prevent the discharge or transfer of the patient.
>
> Note: The Contractors may reimburse a hospital up to 12 calendar days following the period established medically necessary if special circumstances (social necessity) prevent the discharge or transfer of the patient to his/her home or sheltered boarding home and the hospital has taken effective action to stimulate placement of the patient.
>
> Effective action is defined as telephone notification to the County Welfare Board, Division of Youth and Family Service District Office or other responsible officials within one working day of the time that the stay has been determined to be no longer medically necessary. This telephone contact must be then confirmed in writing.
>
> A copy of the written notification must be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).
>
> * * *
>
> Payment for special circumstances (social necessity) is specifically precluded for:
>
> (a) Patients awaiting placement in a Skilled Nursing Facility or Intermediate Care Facility.
>
> (b) Patients for whom a claim has been denied for lack of medical necessity.

(c) Patients who were not eligible recipients as of the date of admission.

It is this regulation which claimant contends violates Federal Medicaid Law and Regulations if it is read literally so as to foreclose the exercise of discretion in its application.

The language of Title XIX confers broad discretion on the State to adopt standards for determining the extent of medical assistance, requiring only that such standards be "reasonable" and "consistent with the objectives of the Act." *Beal* v. *Doe,* above, 53 L. Ed. at 472. Participation by this State in the program was authorized by the enactment of the New Jersey Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 *et seq.* "The stated purpose of the Act was to provide medical assistance, *insofar as practicable,* on behalf of persons whose resources were determined to be inadequate to enable them to secure quality medical care at their own expense, and to enable the State, *within the limits of funds available for any fiscal year for such purposes,* to obtain all benefits for medical assistance provided by the Social Security Act. N.J.S.A. 30:4D-2." *N.J. Federation of Physicians & Dentists* v. *Klein,* 144 N.J. Super. 467, 470 (App Div. 1976). There is no doubt therefore that the Department has the power to adopt reasonable rules and regulations which are necessary to carry out its functions under N.J.S.A. 30:4D-7 and its federal counterpart, 42 U.S.C. §1396 *et seq. In re Fair Hearing,* 138 N.J. Super. 417, 422 (App. Div. 1976).

There is no dispute here with respect to the patients' eligibility for Medicaid assistance, the services rendered, or the amount of each claim. The only dispute is whether Regulation 202.9, as construed by the Director, is in violation of federal requirements that call for reimbursement of all reasonably necessary inpatient hospital services.

A state plan must provide for "payment of the reasonable cost of inpatient hospital services provided under the plan" 42 U.S.C. §1396a(a)(13)(D). Inpatient hospital services are those "services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician * * *." 42 C.F.R. §249.10(a)(1)(6)(i). The State Plan must:

> [S]pecify the amount and/or duration of each item of medical and remedial care and services that will be provided to the categorically needy and to the medically needy, if the plan includes this latter group. Such items must be sufficient in amount, duration and scope to reasonably achieve their purpose with respect to the required services * * *. The state may not arbitrarily deny or reduce the amount, duration or scope of such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition. Appropriate limits may be placed on services based on such criteria as medical necessity of those contained in utilization or medical review procedures. 42 C.F.R. §249.10(a)(5)(i).

The test under the regulation is one of reasonableness: does the State Plan provide services sufficient to "reasonably achieve their purpose?" *Virginia Hospital Ass'n* v. *Kenley,* 427 F. Supp. 781, 785 (E.D. Va. 1977).

In *Commonwealth Dept. of Public Welfare* v. *Temple U. etc.,* 21 Pa. Comwlth 162, 343 A.2d 701 (1975), the issue was raised as to whether it was an abuse of admin-

istrative discretion to deny reimbursement to hospitals which have diligently put forth every effort to locate, without success, an appropriate lesser care facility or a competent relative to accept the patient. In finding that discretion should be exercised, the Commonwealth Court noted:

> • • • In misutilization cases such as this where a patient may no longer be in need of continued acute hospital care but does need some lower level care, we believe that it would be an abuse of administrative discretion to deny reimbursement to hospitals which have diligently put forth every effort to locate, without success, an appropriate lesser care facility or a competent relative for the patient. *In such circumstances there is still a medical necessity for the hospital services.* To hold otherwise would be to read penalty provisions into the regulations where the culpability of the hospital for the particular misutilization involved cannot be established. • • • (Emphasis added) (343 A.2d at 704).

See also, *Department of Public Welfare* v. *Frankford Hospital,* 26 Pa. Comwlth 484, 364 A.2d 957 (1976); *St. Christopher's Hospital* v. *Commonwealth,* —— Pa. Comwlth. ——, 372 A.2d 504 (1977). In *Temple,* the court was dealing with a regulation which permitted the exercise of some administrative discretion based on medical necessity (Pa. Manual §9421.532b.), whereas here the regulation under review, read literally, seems to preclude reimbursement for any period that a patient is awaiting placement to a lesser care facility. We note, however, that our regulation is silent as to reimbursement during a period of the unavailability of a lesser care facility. The

federal statute, 42 U.S.C. 1396, *et seq.* does not mention the eligibility of inpatient services for those awaiting placement; payments are allowed, we note, for care in nursing facilities. 42 U.S.C. 1396a(a)(13)(E).

The Director advises us that the policy inherent in a literal interpretation of the regulation questioned here is not to provide a penalty but to discourage "overutilization" of hospital services, and is rationally related to this State's legitimate interest of maintaining the fiscal solvency of the program.

The Director, relying on judicial approval of statutory limitation on inpatient hospital coverage in *Virginia Hospital Ass'n.* v. *Kenley,* 427 F. Supp. 781 (E.D. Va. 1977), and *Commonwealth, Dept. of Public Welfare* v. *Temple U. etc.,* 21 Pa. Comwlth 162, 343 A.2d 701 (1975), argues that this state properly precludes the reimbursement sought by claimant here. We cannot accept that argument. We disagree with the Virginia case in which the court gave a highly literal construction to the phrase "under the plan" as used in 42 U.S.C. §1396a(a)(13)(D). The phrase should not be read alone but in the context of the option granted to the several states to provide coverage to "medically needy" as well as "categorically needy." See 45 C.F.R. §248.10(a). And while the Pennsylvania case does sanction the 60-day limitation to patient hospital care for the categorically needy as provided by the Commonwealth statute, that case also, as noted heretofore, directed reimbursement to the hospital for care of a patient awaiting placement to a lesser care facility.

The Director also contends that because claimant, by becoming a provider of Medicaid services, has voluntarily agreed to be bound by the regulations promulgated by

him, absent a showing of "coercion, duress, impossibility of performance of, or total absence of statutory authority for this condition of participation," we are without power to alter the terms of that agreement, citing *Briarcliff Haven, Inc.* v. *Department of Hum. Res. Ga.,* 403 F. Supp. 1355 (N.D. Ga. 1975). The difficulty with this argument is that it presupposes that the Director's construction of the questioned regulation accords with the statutory purpose expressed by Congress. In addition, we find the *Briarcliff* case to be inapposite since it dealt with maximum reimbursement ceilings established by the Georgia Department of Human Resources for payment for nursing home services.

Unlike the Virginia, Georgia, and Pennsylvania regulations referred to in *Kenley, Briarcliff Manor,* and *Temple,* above, however, New Jersey fixes no maximum limit to hospital service which is found to be *medically necessary* for a qualified patient. The record here establishes that in all three cases under review it was found to be *medically necessary* to retain the patients under hospital care because no available lesser care facility could be found. That conclusion is not undermined by the fact, undisputed by the Director, that New Jersey is presently experiencing a critical Medicaid nursing home bed shortage, since the primary object of our program is adequate patient care which is found to be medically necessary.

The federal concept of medical necessity is found most clearly defined in those cases dealing with Medicare legislation. 42 U.S.C. §1395, *et seq.* Those cases uniformly hold that an individual who is eligible for extended care coverage does not lose coverage under the act during a period that he is forced to remain in a general hospital for treatment for the sole reason that there is no available

extended care facility available to take him. In *Hayner* v. *Weinberger,* 382 F. Supp. 762 (E.D. N.Y. 1974), the patient was denied benefits under §1395y(a)(9) of the Act because she remained in a hospital when only an extended care facility was required; however, no such facility was available, and it was conceded that the patient, an 83 year old woman with terminal cancer, could not be discharged except to an extended care facility. The court, in reversing the denial of benefits by the Secretary of Health, Education and Welfare, concluded on the theory of "impossibility of performance" and on the facts of the case:

> In determining whether to grant reimbursement in this case we begin with the axiom that "[t]he congressional policy underlying the federal social security legislation requires the courts to interpret the Act liberally, and any doubts should be resolved in favor of coverage." * * * The Act should be construed to effectuate its overriding purpose even if the words used leave room for a contrary interpretation. * * * By providing under 42 U.S.C.A. § 1395f (a)(2)(C) for coverage of treatment in extended care facilities, it seems to us that Congress intended to provide needed treatment to patients who otherwise would be compelled to remain in a general hospital. * * * It would be anomalous to say that Congress intended to leave a gap in coverage for a patient who is lying on her back in a general hospital and who, through no fault of her own, could not immediately obtain extended care treatment elsewhere and at the same time provide such coverage if she could have obtained such treatment in another facility. *We believe that such a denial of*

> *coverage would not only be harsh and unjust but also would not comport with the spirit of the Act.* (Citations omitted; emphasis added), (382 F. Supp. at 765).

See also, *Hultzman* v. *Weinberger,* 495 F. 2d 1276 (3 Cir. 1974); *Torphy* v. *Weinberger,* 384 F. Supp. 1117 (E.D. Wis. 1974).

The Director's argument that the Medicare cases are not applicable in the Medicaid context raises a distinction without any real difference. The Medicare legislation, like the Medicaid legislation, seeks to encourage the efficient and economical use of medical facilities. Both have as their goal the availability of services *medically necessary* for patients eligible under the respective acts. The controlling factor is not *where* the service or treatment is performed but *whether* it is medically necessary. Under this factor there can be no "misutilization" if no lesser care facility is available.

There is nothing in the record here which would support the conclusion that the services rendered to the three patients involved were not medically reasonable and necessary. What evidence there is points to the contrary. And, as noted, the hearing officer concluded that the services were needed in each of the cases.

Accordingly, we conclude that the Director erroneously interpreted the applicable regulation (Hospital Services Manual §§ 202.9 Note; N.J.A.C. 10:52-1.2(a)) 18 Note, (b)(1)) so as to exclude any exercise of discretion in circumstances such as those presented by the cases of the three patients in question. Such discretion should be exercised when the provider (who has the burden) can demonstrate the medical necessity for the treatment or

services provided to the patient, the need for a release of the patient only to a lesser care facility, the efforts made by it to place the patient in such facility, and the unavailability of the required facility.

II

Claimant also argues that due process mandates a predetermination hearing be held before any medicaid recipient, such as each whose case is involved here, is cut off from the receipt of benefits. The Director contends that claimant has no standing to raise this issue. We disagree. Claimant, as a Medicaid provider, is a party directly affected by the non-reimbursement of the benefits in question. N.J.S.A. 30:4D-7(f) specifically provides "that either the recipient or the provider shall be afforded the opportunity for a fair hearing within a reasonable time on any valid complaint." Furthermore, N.J.A.C. 10:49-1.13 requires that "all providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process." The plaintiff's rights in the process are to be considered in conjunction with the recipients: It is the provider that is injured when reimbursement is denied, not the recipient. See, *e.g., Rosado* v. *Wyman,* 397 U.S. 397 (1970); *Singleton* v. *Wulff,* 428 U.S. 106 (1976); *Massachusetts General Hospital* v. *Sargent,* 397 F. Supp. 1056, 1059 (D. Mass. 1975); *Nat. U. of Hosp. & Health Care Emp. etc.* v. *Carey,* 557 F.2d 278, 280-281 (2d Cir. 1977). In *Goldberg* v. *Kelly,* 397 U.S. 254 (1970), the court established the test to determine when a predetermination hearing must be held prior to the effectiveness of an administrative order. "The extent to which procedural due process must be afforded

the recipient is influenced by the extent to which he 'may be condemned to suffer grievous loss,' • • • and depends upon whether the recipient's interest in avoiding that loss outweighs the governmental interest in summary adjudication." (397 U.S. at 262-263).

Goldberg involved the termination of welfare benefits without a predetermination hearing. The court concluded that when welfare is discontinued, only a predetermination evidentiary hearing provides the recipient with procedural due process since "termination of aid pending resolution of a controversy over eligibility may deprive an *eligible* recipient of the very means by which to live while he waits.• • • His need to concentrate upon finding the means for daily subsistence, in turn, adversely affects his ability to seek redress from the welfare bureaucracy." (397 U.S. at 264).

The decision whether a predetermination hearing is necessary depends on the balancing factors peculiar to the litigation. The post-determination here involved would not leave recipients "destitute," unlike the situation presented in *Goldberg*. A denial of an inpatient hospital claim and subsequent proceedings by the hospital against the recipient will not result in a total loss of subsistence or a further loss of medical benefits.

Providers, such as claimant, are aware of rules and regulations set forth by the plan, which they are required to follow. They are not completely without notice as to the services that may be offered. Claimant was entitled to and received a fair hearing as to termination of benefits followed by an appeal. Accordingly, the right to be heard "at a meaningful time and in a meaningful manner," *Armstrong* v. *Manzo,* 380 U.S. 545 (1965) is

satisfied by the provision for a post-denial hearing on behalf of the recipient where he seeks to challenge the determination. Compare *Mercy General Hospital* v. *Weinberger,* 410 F. Supp. 344 (E.D. Mich. 1975).

The determinations of the Director of the Division of Medical Assistance and Health Services, insofar as it denies reimbursement to claimant for the waiting periods mentioned herein, are reversed.

APPENDIX C

Determination of the Director of the Division of Medical Assistance and Health Services

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

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FAIR HEARING DECISION
MONMOUTH MEDICAL CENTER

RE: LUTHER TOWNSEND
MADELINE B. PAPIKAS
JAMES REMPKOWSKI
WILSON LOPEZ

DIRECTOR'S DECISION

The Director, Division of Medical Assistance and Health Services, has reviewed the entire record in this matter, including the Hearing Officer's Report and exceptions thereto, and makes the following determination:

LUTHER TOWNSEND

The regulation (202.9 in the Hospital Manual) cited by the Hearing Officer authorizing payment when

special circumstances (social necessity) prevent discharge or transfer of the patient specifically precludes payment for patients awaiting placement in a Skilled Nursing Facility or Intermediate Care Facility (also referred to as nursing homes). In addition, said regulation is binding on the Division as well as the contractors. Therefore, the Director hereby reverses the Hearing Officer's recommendation and denies payment for the period in question.

MADELINE B. PAPIKAS

After conducting his review in this case, the Director finds that the main problem was the difficulty the patient experienced in obtaining her Supplemental Security Income (SSI) checks from Social Security.

As the Hearing Officer indicated on page 6, paragraph 1, of his report, Monmouth Medical Center experienced difficulty in obtaining a Medicaid number or convincing the local Social Security office to release the SSI checks. Said checks were not available to the patient until December 5, 1974 (transcript, page 42; Line 22, 23). The patient was subsequently discharged on December 10, 1974.

Therefore, in view of the above, the Director hereby modifies the Hearing Officer's recommendation to allow payment up to and including December 5, 1974, which was the date eligibility was clearly established.

JAMES REPKOWSKI

The Director hereby modifies the Hearing Officer's recommendation to allow payment up to and includ-

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ing February 19, 1976, which was the effective date of eligibility for this patient. The facts of this case are similar to the Papikas case, as Monmouth Medical Center experienced delays in obtaining an eligibility determination from the various social agencies involved.

However, no payment can be made beyond this date because Regulation 202.9, referred to above, precludes payment for patients awaiting nursing home placement.

WILSON LOPEZ

The Director hereby affirms the Hearing Officer's recommendation to deny payment.

This decision constitutes final agency action.

EFFECTIVE DATE: February 8, 1977

Gerald J. Reilly, Director
Division of Medical Assistance
and Health Services

APPENDIX D

Recommended Findings of Fact and Conclusions of Law of the Hearing Officer for the Division of Medical Assistance and Health Services

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

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STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES

FAIR HEARING DECISION: MONMOUTH MEDICAL CENTER

RE: LUTHER TOWNSEND, HSP #1320-004770-01
MADELINE PAPIKAS, HSP #1320-536005-01
JAMES REMPKOWSKI, HSP #1520-900116-01
WILSON LOPEZ, HSP #1660-008115-24

On August 13, 1976 a Fair Hearing was held at the offices of the Division of Medical Assistance and Health Services, 324 East State Street, Trenton, New Jersey.

The hearing was held before Gregory Danese, Esquire, Hearing Officer, Division of Medical Assistance and Health Services.

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Appearing on behalf of the Division of Medical Assistance and Health Services were:

James E.D. Gardam, M.D., Medical Director
Governmental Health Programs Department
The Prudential Insurance Company of America

Teri Rainear, Assistant Supervisor
Claims Approver
The Prudential Insurance Company of America

Appearing on behalf of the Monmouth Medical Center were:

Frank R. Ciesla, Jr., Esquire
Attorney for Monmouth Medical Center

James C. Kirby, M.D.
Chairman, Utilization Review Committee

Vincent G. Raine, Assistance Controller
Monmouth Medical Center

Floreine Cunningham
Coordinator of Social Services
Monmouth Medical Center

This request for hearing was filed by Vincent G. Raine on behalf of Monmouth Medical Center, hereinafter referred to as the appellant, and concerns the denial of payment for inpatient hospital services rendered to the above Medicaid recipients. The Prudential Insurance Company of America, the intermediary for the Division of Medical Assistance and Health Services, reviewed the claims and determined that the care rendered or portion of the care rendered was not medically required in an inpatient hospital setting; therefore, payment was denied.

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A verbatim transcript of the hearing was taken by Alvin A. Nerline, Certified Shorthand Reporter. The Hearing Officer and Mr. Ciesla agreed that the Shorthand Reporter and the Hearing Officer's transcript copy would be provided at the expense of the appellant.

The following documentation was submitted by the appellant:

A-1 Pretrial Hearing Brief

A-2 Letter from Paul Scavuzzo concerning persons awaiting Medicaid beds in skilled nursing facilities

A-3 General Admission Consent of Wilson Lopez

A-4 Letter from Arthur Penn of the Public Advocate's Office concerning a nursing home bed shortage

A-5 United States General Accounting Office Report #B-164031(3)

Although A-4 and A-5 were submitted after the hearing, the Hearing Officer considered this information since copies were provided to Doctor Gardam and the material did not deal with the issue of medical necessity.

LUTHER TOWNSEND, HSP #1320-004770-01

Luther Townsend was hospitalized from April 7, 1975 to May 28, 1975. Prudential denied payment for the period from May 8, 1975 to May 28, 1975 (copies of records submitted indicate denial was from May 9, 1975 to May 28, 1975). The denial was based upon Section 202.9 of the Hospital Services Manual, since it was determined by Prudential that the patient after May 8, 1975 did not medically require acute hospital care; that the care the pa-

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tient did require could have been provided in a skilled nursing facility.

The following is a summary of the information presented in testimony by James E. D. Gardam, M.D. (Testimony by Dr. Gardam begins on page 10 of the transcript).

The patient, a 55 year old male with a history of alcoholism and chronic epilepsy, was admitted to the Monmouth Medical Center Emergency Room with a broken hip on April 7, 1975.

Surgery was performed on the hip eight days after admission due to the fact that the patient had symptoms suggestive of the DT's and a history of convulsions. The admission and delay in surgery were justified.

Three days after the operation, the patient went to physiotherapy and experienced problems in weight bearing. There was a possible shift in the prosthesis and the patient was placed back on bed rest and limited physiotherapy. It was the recommendation of the attending physician that the patient be off his leg for at least another four months.

The hospital records indicate that on April 29, 1975, social services was notified to prepare the patient for nursing home placement. A further review of the records indicate that the medical requirements of the patient after May 8, 1975 did not require an acute hospital setting, that such care could have been provided in a lesser care facility and, therefore, payment was denied for the period from May 8, 1975 to May 28, 1975.

In response to a question from Mr. Ciesla, Dr. Gardam stated that during the period of denial the patient required care in a lesser care facility with services of physiotherapy and skilled nursing observation. (p. 15)

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The following is a summary of the information presented in testimony by James C. Kirby, M.D., Chairman, Utilization Review Committee. (Testimony by Dr. Kirby begins on page 16 of the transcript)

Dr. Kirby agreed with the description of the patient provided by Dr. Gardam. He also agreed that from May 8, 1975 to May 28, 1975, the patient required care which could have been provided in a facility having a lesser intensity of services. However, Monmouth Medical Center was not able to place the patient in a skilled or Intermediate Care Facility until May 28, 1975.

In response to a question from Mr. Ciesla, Dr. Kirby stated that the only place the patient could have been discharged to was the street. It was Dr. Kirby's opinion that if a patient requires skilled nursing care, it would be negligence on the part of the institution to discharge a patient to a non-skilled environment. Dr. Kirby further added that to discharge someone in Mr. Townsend's condition to a non-skilled environment would, in his opinion, constitute negligence.

The following is a summary of the information presented in testimony by Mrs. Floreine Cunningham, Coordinator of Social Services on April 9, 1975.

Nursing Homes and Intermediate Care Facilities in Monmouth and Ocean Counties were canvassed for available beds. The first available bed was at an Intermediate Care Facility on May 28, 1975. Monmouth Medical Center does not contact nursing homes north of Monmouth County, since there is a lack of beds in such counties and Monmouth County nursing homes are already full of patients from New York and northern New Jersey.

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In response to a question from the Hearing Officer, Mrs. Cunningham stated that there are approximately twenty-nine to thirty nursing homes which are canvassed daily.

Mr. Ciesla introduced a letter from Mr. Paul Scavuzzo, Local Administrator, Monmouth Local Medical Assistance, which indicated the Medicaid backlog in Monmouth and Ocean Counties from October, 1975 through June, 1976. Mr. Ciesla requested that administrative notice of the letter be taken.

CONCLUSION AND RECOMMENDATION

Both sides agree that from May 8, 1975 to May 28, 1975, the period for which payment was denied, the patient required care in a Skilled Nursing Facility and could not be discharged to care for himself. The Hearing Officer also finds that the Monmouth Medical Center attempted to place the patient in a Skilled Nursing Facility and was not able to place the patient until May 28, 1976, when the patient was placed in an Intermediate Care Facility.

The issue to be determined is whether or not Monmouth Medical Center should be denied payment for the care rendered to Mr. Townsend for the period from May 8, 1975 to May 28, 1975.

The denial was based upon Sections 202 and 202.9 of the Hospital Services Manual which are derived from Title 10 of the New Jersey Administrative Code and provide:

202. NON-COVERED INPATIENT HOSPITAL SERVICES

Benefits are not payable for any services rendered or items dispensed or furnished in connection with:

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202.9 *Services Rendered After Day Medically Necessary* Inpatient hospital services rendered after the day it is medically necessary, except when *special circumstances* prevent the discharge or transfer of the patient.

NOTE: The Contractors may reimburse a hospital up to 12 calendar days following the period established as being medically necessary if special circumstances (social necessity) prevent the discharge or transfer of the patient to his/her home or sheltered boarding home and the hospital has taken effective action to stimulate placement of the patient.

Effective action is defined as telephone notification to the County Welfare Board, Division of Youth & Family Services District Office or other responsible officials within one working day of the time that the stay has been determined to be no longer medically necessary. This telephone contact must be then confirmed in writing.

A copy of the written notification must be submitted with all claims for which reimbursement is claimed for special circumstances (social necessity).

Payment for Special Circumstances (Social Necessity) is specifically procluded for:

a. Patients awaiting placement in a Skilled Nursing Facility or Intermediate Care Facility.

b. Patients for whom a claim has been denied for lack of medical necessity.

c. Patients who were not eligible recipients as of the date of admission.

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The Hearing Office finds that the facts in the present case constitute special circumstances and recommends that Monmouth Medical Center be paid for the period denied.

The special circumstances are:

1. The fact that after May 8, 1975 the patient required care in a Skilled Nursing Facility, and could not be released to care for himself.
2. The hospital made good faith efforts to locate a Skilled Nursing Facility; however, there were no openings in the Monmouth-Ocean County area.
3. The patient was placed in an Intermediate Care Facility on May 28, 1975.

The Hearing Officer finds that the "NOTE" in Section 202.9 of the Hospital Service Manual is directed to the contractor. Therefore, the provision precluding social necessity payments for patients awaiting placement in a Skilled Nursing Facility or Intermediate Care Facility does not apply to the Hearing Officer.

MADELINE B. PAPIKAS, HSP #1320-536005-01

From testimony presented by both parties, Madeline Papikas was hospitalized from April 9, 1974 to December 5, 1975. Prudential denied payment for a period of 99 days.

Mr. Raines' letter of August 13, 1975 to Gerald J. Reilly, Director, indicates that the dates of service are from June 1, 1974 to December 10, 1974 with Prudential denying the period from September 1, 1974 to December 10, 1974, a period of 99 days.

The denial was based upon Section 202.9 of the Hospital Services Manual, since it was determined by Prudential

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that the patient did not medically require acute hospital care for the period denied; that the care the patient did require could have been provided in a lesser care facility.

Dr. Gardam presented testimony beginning on page 33 of the transcript, which described the patient as a 47 year old female, admitted with cirrhosis of the liver and whose initial course in the hospital was chronic liver and kidney failure. The patient improved to a point where she could have been transferred to a Skilled Nursing Facility or Intermediate Care Facility; however, she could not be discharged to a non-skilled environment. In response to a question from Mr. Ciesla, Dr. Gardam stated that the patient required care in a Skilled Nursing Facility or Intermediate Care Facility for a certain period.

Dr. Kirby referred to his testimony given concerning the Townsend claim, that to discharge a person in Mrs. Papikas' condition to a non-skilled environment would constitute negligence on the part of the hospital.

Mrs. Cunningham testified, beginning on page 39 of the transcript, to the difficulties Monmouth Medical Center encountered with the Social Security Administration, the Local Welfare Director, and the Monmouth County Welfare Board, in obtaining a Medicaid number for the patient. When Mrs. Papikas was approved for SSI benefits, the local Social Security office would not release her checks, since she had no home address. (This point was clarified in Dr. Kirby's July 10, 1975 letter to Dr. Brewer, A-6). Mrs. Papikas had no home address because she was in the Monmouth Medical Center and the apartment she rented prior to hospitalization was rented out to another tenant by her landlord. After appealing to the New York Regional Social Security Office, the funds were released to Mrs. Papikas who was then discharged to an apartment social services had found for her.

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CONCLUSION AND RECOMMENDATION

The denial was based upon Sections 202 and 202.9 of the Hospital Services Manual as previously set forth.

Based upon testimony from Dr. Gardam and Dr. Kirby, the Hearing Officer finds that the patient required skilled nursing care for part of the period of denial. It was never brought out at the hearing which portion of the denial period the patient required skilled nursing care, and for which portion of the period she could not be discharged, because Social Security would not release her checks.

The Hearing Officer finds that the Monmouth Medical Center attempted to obtain assistance for this patient through the Local Welfare Director, Local Welfare Board, and Social Security Administration for the purpose of placing the patient in a nursing facility, and then for the purpose of discharging the patient to an apartment. The Monmouth Medical Center could not place the patient in a nursing home or discharge her to an apartment due to the actions of these three governmental agencies. The patient could not be discharged to an apartment found for her, because the Social Security Office would not release Mrs. Papikas' checks without a home address. Once the Social Security checks were released, the patient was immediately placed in an apartment.

The Hearing Officer finds that the facts in the present case constitute special circumstances and recommends that Monmouth Medical Center be paid for the period denied.

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JAMES REMPKOWSKI, HSP #1520-900116-01

James Rempkowski was hospitalized from November 23, 1975 to March 9, 1976. Prudential denied payment for the period from January 13, 1976 to March 9, 1976. The denial was based upon Section 202.9 of the Hospital Services Manual, since it was determined by Prudential that inpatient hospital care was not medically required.

The following information was presented in testimony by Dr. Gardam beginning on page 48 of the transcript:

The patient apparently had been drinking, had vomited and had breathed in some of the material producing a cardiac arrest. He was resuscitated, but suffered brain and kidney damage. The patient remained in the hospital for 107 days. Intensive medical care was required for the period from November 23, 1975 to January 13, 1976.

Prudential carefully reviewed the claim to allow for every possible payment, since the patient required kidney dialysis.

The Utilization Review Committee in response to correspondence from Prudential agreed that the patient became a disposition problem on or about January 13th; that there was a decrease in the medical necessity for acute bed care at that time.

The institution experienced problems with the patient's eligibility. Prudential was not able to determine when the patient's problem was referred to Social Services. At the time of the patient's admission, there was clear-cut evidence of no insurance. Dr. Gardam felt that efforts should have been made to initiate coverage on the date of admission or the next working day. The Social Serv-

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ice notes indicate the patient was referred on December 2nd or 4th. Application for Supplemental Security Income was made on December 12th.

It was Dr. Gardam's position that Monmouth Medical Center should have made attempts to determine eligibility at the time of admission.

Dr. Gardam agreed that the patient required care in a skilled nursing home facility from January 13th on.

Mr. Ciesla then referred to the testimony of Dr. Kirby that Monmouth Medical Center would be negligent to discharge a patient requiring skilled nursing care to a non-skilled environment.

The following information was presented in testimony by Mrs. Cunningham beginning on page 52 of the transcript:

Mr. Rempkowski was admitted on 11/23/75 to the Intensive Care Unit. On 12/2/75 he was referred to Social Services. On 12/4/75 a representative from Social Security took an SSI application. The patient was referred to the Rehabilitation Commission on 12/30/75 to see if they would cover part of the stay. This request was turned down. On 1/21/76 the Social Security Office was called to expedite the case. The Local Welfare Director was contacted. On 1/27/76 attempts were made to contact the patient's sister and on 1/29/76 the Monmouth County Welfare Board verified that the patient had lived in Keansburg. On 2/17/76 the Social Security Office informed Social Services that the case was referred to Monmouth County Welfare Board for a Medicaid number; that the application was approved, but there was no number. On the same date the Medicaid office was called and they said a number would be assigned as soon as possible.

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On February 19th, the hospital received the number and the patient was discharged to Bayview Convalescent Center on March 9, 1976. As previously stated, a Medicaid recipient cannot be placed in a nursing home without a Medicaid number.

Conclusion and Recommendation

The denial was based upon Sections 202 and 202.9 of the Hospital Services Manual as previously set forth.

Based upon testimony by Dr. Gardam and a review of the medical documents submitted, the Hearing Officer finds that the patient required skilled nursing care for the period denied. The Hearing Officer also finds that upon admission to the hospital, the patient was placed in the Intensive Care Unit and unable to communicate. He was referred to Social Services on December 2, 1975.

The Hearing Officer finds that during the period from December 2, 1975 until the patient's discharge to Bayview Convalescent Center on March 9, 1976, the appellant made many attempts through the appropriate governmental agencies, as set forth in the record, to have the patient approved for Medicaid. The delay in approval was not the fault of the appellant. Once the patient was approved for Medicaid, he was placed in the Bayview Convalescent Center.

The Hearing Officer finds that the facts in the present case constitute special circumstances and recommends that Monmouth Medical Center be paid for the period denied.

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WILSON LOPEZ, HSP #1660-008115-24

Wilson Lopez was hospitalized from July 23, 1975 to July 29, 1975. Prudential denied payment for a period of five days. The denial was based upon Section 201.15 of the Hospital Services Manual, services in connection with a dental condition; that such services could have been performed on an outpatient basis, since there was no medical necessity for inpatient hospital care.

Dr. Gardam had some critical comments concerning the records kept on this patient. Testimony begins on page 54 of the transcript.

The patient was a 16 year old Puerto Rican male. The preoperative diagnosis was "Rampent Dental Caries in an emotionally disturbed".

The records are specific concerning the number of fillings, since this is the basis for reimbursement. However, the records are vague in describing which specific teeth were involved and how each tooth was treated. There is no mention of the degree of emotional disturbance.

The records do not indicate medical necessity for the admission. The patient is described as a young, disagreeable male admitted for elective denial surgery; however, this is not medical justification for admission to the hospital.

Dr. Gardam testified that there is no evidence of medical necessity for admission. A physical examination of the patient indicated he was well developed, well nourished and attending school.

Dr. Gardam was informed that prior authorization was granted, and although prior authorization is an administrative procedure that states there is medical necessity for an admission, the carrier still reviews such admission to determine medical necessity. In the present case the records do not indicate any consultation or approval by the local Medicaid office.

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The records in this case do not indicate a need for the patient to be admitted and have the dental work performed under a general anesthesia.

Mr. Ciesla introduced into evidence the following forms: Consent for Admission to the hospital; Consent to operation and medical services; and a release from responsibility for personal property (A-3).

The following information was presented in testimony by Dr. Kirby, beginning on page 64 of the transcript:

The Utilization Review Committee reviewed the patient's record and discussed it with the physician and dentist involved. Although the degree of emotional instability was not documented, having the patient's dental work performed in the hospital under general anesthesia seemed a justifiable thing.

It is a common practice that emotionally disturbed children and adults be worked on under general anesthesia. Dr. Kirby agreed with Dr. Gardam that there was no definite statement concerning the degree of the patient's emotional illness.

In response to a question from Mr. Ciesla, Dr. Gardam stated that it is acceptable medical practice to use a general anesthesia in the case of an emotionally disturbed person.

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CONCLUSION AND RECOMMENDATION

The Hearing Officer finds that the patient was admitted to Monmouth Medical Center for treatment of rampent dental caries. During his stay at the hospital, extensive dental work was performed on his teeth as set forth in the hospital records and described by Dr. Gardam on pages 56 and 57 of the transcript. Although the patient is described as emotionally disturbed, there is no indication or explanation of the degree of emotional disturbance other than he was a young, disagreeable male. Other evidence indicated the patient was in good physical condition.

Mr. Raine's letter of April 12, 1976 to Mr. Reilly (E-1) states that arrangements for the admission of the patient to Monmouth Medical Center was made by the Division of Youth and Family Services and the "Division of Medicaid." However, there is no evidence in the transcript or records submitted to show the involvement of the Division of Medical Assistance and Health Services.

Other than the consent forms, which according to Mr. Ciesla were signed by a social worker from the Division of Youth and Family Services, the appellant produced no evidence to indicate the degree of involvement by the Division of Youth and Family Services in having the patient admitted.

The appellant did not introduce any evidence to prove there was prior authorization for the dental services provided to the patient.

The Hearing Officer finds that Wilson Lopez did not medically require inpatient hospital care for the period denied and that such patient was not admitted pursuant to Section 201.15 of the Hospital Services Manual. The Hearing

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Officer recommends that the decision of Prudential to deny payment be upheld.

October 28, 1976

Gregory Danese, Hearing Officer
Division of Medical Assistance and
Health Services New Jersey
Department of Institutions and
Agencies

SUPREME COURT, U.S.
FILED
OCT 13 1979
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-430

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Petitioners,

vs.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

BRIEF IN OPPOSITION TO PETITIONERS' PETITION FOR WRIT OF CERTIORARI

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B. The alleged additional financial burden assumed by the State under the Supreme Court's decision to extend coverage to Medicaid recipients who are unavoidably retained in a hospital for treatment constitutes an inaccurate representation of facts and statements, which under United States Supreme Court Rule 23(4), is sufficient reason for denying the petition 5

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1979

No. 79-430

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services of the State of New Jersey,

Petitioners,

vs.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey,

Respondent.

BRIEF IN OPPOSITION TO PETITIONERS' PETITION FOR WRIT OF CERTIORARI

STATEMENT OF THE CASE

The parties to this proceeding are: Monmouth Medical Center (hereinafter referred to as "respondent" or "Center"), a non-profit hospital located in Long Branch, New Jersey, which is a provider of medical assistance and care under New Jersey's Medicaid Program; Monmouth Medical Center, on behalf of Luther Townsend, Madeline B. Papikas, and James Rempkowski, beneficiaries; Ann Klein, the Commissioner of the Department of Human Resources of the State of New Jersey (formerly the De-

partment of Institutions and Agencies), and Thomas M. Russo,[1] the Director of the Division of Medical Assistance and Health Services in the State of New Jersey (hereinafter collectively referred to as the "petitioners").

The patients involved in this action received inpatient hospital care until they were well enough to be discharged or transferred to a lesser care facility. However, due to the extreme shortage of these lesser care facilities in the area, it was necessary for the provider of services, Monmouth Medical Center, to render necessary medical care to the patients within the hospital while it searched for available space in one of these facilities.

Federal law requires that a state Medicaid plan specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the needy. Such items must be "sufficient in amount, duration and scope to reasonably achieve their purpose." Also, under federal regulations, the state may not arbitrarily deny or reduce the amount, duration, or scope of, such services solely because of the patient's diagnosis, type of illness or condition. 45 C.F.R. 249.10(a)(5)(i).

The New Jersey Division of Medical Assistance and Health Services based the denials in the matters of Townsend, Papikas, and Rempkowski on Regulation 202.9 of New Jersey Hospital Manual which provides that hospital services rendered after the day it is medically necessary are not payable, except when special circumstances are specially precluded for patients awaiting placement in a skilled nursing facility or intermediate care facility.

The Court found that the Director's finding, that medically necessary care received in a hospital setting is not

1. Mr. Russo has apparently replaced Mr. Gerald J. Rielly.

medically necessary simply because such care might have been provided in a lesser care facility, is inconsistent with and conflicts with appropriate federal law. The denial of payments on behalf of a Medicaid recipient, merely because no lesser care facility is immediately available to him, is erroneous in light of federal law which interprets medical necessity, in accordance with the full purposes and objectives of the Medicare Program, to be that care which is reasonable and necessary for a particular patient's health and well-being without regard to where the patient receives such care.

The Supreme Court of New Jersey correctly found that to read New Jersey's Medicaid Plan so literally as to preclude payments in situations where necessary care is rendered to patients during periods when such patients are unavoidably forced to remain in the hospital is inconsistent with the goal of the Medicaid program which seeks to assure that "needed" medical care is provided to beneficiaries.

ARGUMENT

Petitioner's Petition for Writ of Certiorari should be denied in that it misstates the issue decided by the Supreme Court of New Jersey, is riddled with inaccurate facts and statements, and incorrectly asserts that the decision conflicts with Federal and State judiciary interpretations of the HEW regulations.

A. *Certiorari should be denied since the Petition misstates the issue the Supreme Court of New Jersey correctly decided*

Contrary to the broad questions raised by the petitioners, the New Jersey Supreme Court decision in affirming the lower court rested on the method of payment utilized by the Medicaid program. The state has adopted a generally accepted "per diem" payment method for services rendered to beneficiaries (Medicare and Blue Cross also reimburse New Jersey hospitals under this method). Under this method the hospital's total reasonable and allowable costs are divided by the total number of patient days. The medicaid program, as a third party payor, then pays the per diem rate for each "allowed" day. As recognized by the New Jersey Supreme Court, "reimbursement is at a flat rate irrespective of the level of care rendered or the actual costs incurred" (App. A at 12a). Assuming, arguendo, that the cost of necessary medical care was incurred while a patient was awaiting transfer to a lesser care facility, then the "per diem" rate to medicaid would be reduced for all medicaid days. For instance, if a patient needed care in the acute care setting, which care cost $300.00 a day, and another patient was receiving medically necessary care while awaiting transfer to a lesser care facility, which care cost $100.00 a day, and these were the

only two patients in the hospital, Medicaid would pay $200.00 a day for each allowable day.

If the state should prevail then Medicaid would avoid paying the full costs of the acknowledged day ($300.00 in the above example), as well as saving the payment it would have been obligated to make to the lesser care facility if the patient had been transferred. If this Court should reverse, then Medicaid would not be required to pay the hospital any sum for the services actually rendered. It is the best of all possible worlds to the Medicaid program. If the hospital had been able to transfer the patient as soon as the level of medical necessity could be delivered at a lesser care facility, then Medicaid would have paid a higher "per diem" rate to the hospital on all other Medicaid patient days as well as the payment to the lesser care facility.

B. *The alleged additional financial burden assumed by the State under the Supreme Court's decision to extend coverage to Medicaid recipients who are unavoidably retained in a hospital for treatment constitutes an inaccurate representation of facts and statements which, under United States Supreme Court Rule 23(4), is sufficient reason for denying the petition*

When the state of New Jersey adopted our present Medicaid plan it accepted full responsibility for complying with all of the conditions of participation which Congress set out in the governing federal statute. Two of these conditions require that state plans assure that medical care is made available to beneficiaries consistent with the "best interests" of the recipients (42 U.S.C. §1396a(a)(19)) and that the state plans be funded in such a manner as to assure that the "lack of adequate funds from local sources will not result in lowering the amount, duration,

scope, or quality of care and services." 42 U.S.C. §1396a (a)(2).

Despite the above, the respondents contend that New Jersey cannot afford to reimburse hospitals for care it renders to Medicaid recipients during unavoidably prolonged stays, regardless of the reasonableness of the care that is provided. As set forth in Point I, the state avoids the legitimate expenses only if it continues this intolerable shortage.

In light of the New Jersey Supreme Court finding that:

> "the main obstacle to placing Medicaid patients is the critical statewide shortage of Medicaid-available beds in skilled care facilities. The State, however, is not powerless to alleviate that condition. It can both facilitate the construction of new health centers—as well as the expansion of existing institutions—and may encourage such facilities to make a greater number of spaces available to Medicaid recipients. The State's failure to remedy the nursing home shortage cannot now be used to justify penalizing hospitals which exercise due diligence in placing their patients.
>
> In addition to the above considerations, we cannot ignore the real impact upon the public denying reimbursement. To the extent that a hospital is not recompensed for services rendered, it will have to absorb the costs itself. This in turn will compel the hospital to pass on these unreimbursed costs to the non-indigent persons who utilize its facilities. Thus, the costs of providing for the indigent will be borne solely by those unfortunate enough to require hospital care, rather than being spread among State and national taxpayers. In our opinion, it is more just and equitable to spread the costs." (App. A at 15a, footnotes omitted.)

A better analysis of the additional expense set forth in the footnote on page 7 of Petitioner's brief is one which

reveals that, if lesser care facilities were available for medicaid patients, the State would have been obligated to spend such funds to pay the lesser care facilities as well as the higher "per diem". For this Court to reverse the New Jersey Supreme Court decision would be a powerful incentive, if not conclusive, for the Medicaid program to maintain the intolerable lesser care facility shortage![2]

As Monmouth Medical Center has established, Congress did not intend on allowing the financial status of a particular state to interfere with the attainment of the goals of the Medicaid program. In addition, it should be noted that the alternative to New Jersey accepting its responsibility in these matters is for New Jersey's hospitals to continue to absorb the financial loss imposed on them by the state's repeated failure to exercise any administrative discretion towards allowing reimbursement in cases where necessary care is rendered to beneficiaries who are forced to remain in the hospital setting. Using Commissioner Klein's own figure, if New Jersey's hospitals are compelled to annually render free care costing the hospitals over 37 million dollars, there can be no question that this policy will have an adverse effect on the providing of health care in our state. Providers cannot be expected to absorb such a loss without making extraordinary cutbacks in services provided or making significant increases in the cost of

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2. In the early stages of this decade, the State placed moratoriums on the construction of new nursing home facilities, which were upheld by the New Jersey courts. *See Cooper River Convalescent Center v. Dougherty*, 133 N.J. Super. 226, 336 A.2d 35 (App. Div. 1975); *Merry Heart Nursing and Convalescent Home v. Dougherty*, 131 N.J. Super. 412, 330 A.2d 370 (App. Div. 1974). It does not strain one's imagination to comprehend that the current intolerable nursing home shortage is the direct result of the aforesaid State policymaking decisions. Although this policy is the source of the predicament that the hospitals presently find themselves in, the State seeks to unjustly place the financial burden of providing care to these patients on the providers. The petitioners ask this Court to make the hospitals bear the cost of additional expenses incurred as a result of the unforeseen adverse consequences of the State's nursing home policies.

health care. Accordingly, not only will Medicaid recipients continue to be harmed by the policy of the respondents but all citizens of New Jersey will suffer at the hands of our state's health care administrators.

In light of the above, the financial aspects of this case urged by petitioners to be a controlling factor in considering their argument for reversal of the lower court's decision in fact constitute a series of factual inaccuracies, which under Supreme Court Rule 23(4), is a sufficient reason for denying a petition.

C. *The decision of the Supreme Court of New Jersey does not conflict with interpretations of the Medicaid statute that have been given by the Federal and State judiciary and HEW*

Petitioners assert in Part B of their Brief that this Court must review the decision of the New Jersey Supreme Court in order to resolve the conflicting interpretations of the Medicaid Statute that have been given by Federal and State courts. Petitioners' Brief at 21. The State contends that the Supreme Court found that *all* medically necessary services rendered by a provider must be reimbursed and that this holding was in conflict with several federal cases. *Id.* at 21-22. This assertion is utterly frivolous, in that the Supreme Court of New Jersey expressly stated that this was *not* the basis for its decision:

> Courts in other jurisdictions have divided upon the issue of whether a state must provide reimbursement for all medically necessary inpatient services provided each individual patient. We, however, find it unnecessary to join that particular fray inasmuch as we conclude that the State regulation here at issue is unreasonable and hence invalid even under the State's interpretation of federal requirements (citations omitted).

App. A at 12a. The Court summarized the reimbursement procedures as follows:

> Hospitals contract with the State to provide medical services to the indigent. Under this agreement, hospitals which have provided such services to Medicaid eligible patients may file for reimbursement from the State. Reimbursement is at a flat *per diem* rate irrespective of the level of care rendered or the actual costs incurred. The State also reimburses skilled nursing homes and intermediate care facilities for reasonable expenditures made wtih respect to Medicaid recipients. Inasmuch as such facilities render less intensive services than do hospitals, however, their *per diem* reimbursement rate is considerably lower.

App. A at 12a.

Neither the Respondent nor the Court dispute the fact that the State of New Jersey was given wide latitude in developing its present Medicaid program or that the State was allowed to use its discretion to decide exactly who would be covered under the plan.

The Court merely held that although the State's purpose in saving tax dollars and preventing misutilization of facilities was a laudatory objective, the means by which the State attempted to achieve this goal was unlawful. The regulation, in attempting to prevent misutilization of hospital facilities, penalized providers not because of their own laxity, but, solely because of circumstances beyond their control. Thus the regulation was struck down as unconstitutionally overbroad. The Court was not concerned with determining whether the State has to provide

reimbursement for *all* medically necessary inpatient services.

The Court further stated that the equitable solution in this instance "would be to reimburse hospitals in such circumstances at a rate commensurate with that of the lesser care facility which could provide the needed services." App. A at 14a. Thus, it is clear that the decision of the Supreme Court of New Jersey did not address the broad issues referred to in Petitioners' Brief. It merely invalidated a regulation which penalized Respondent solely because of circumstances beyond its control.

Respondent does not contend that the broad questions asserted by Petitioners are not important matters which at some time may be reviewed by this Court. However, the Center argues that the present action is not the appropriate means of proceeding with such review. As stated by this Court, a petition for certiorari is often denied even though certain "technical requirements" are met:

> Pertinent considerations of judicial policy here come into play. A case may raise an important question but the record may be cloudy. It may be desirable to have different aspects of an issue further illumined by the lower courts. Wise adjudication has its own time for ripening.

Maryland v. Baltimore Radio Show, 338 U.S. 912, 918, 70 S. Ct. 252, 94 L.Ed. 562, 566 (1950); *see also Rice v. Sioux City Cemetery*, 349 U.S. 70, 75 S. Ct. 614, 99 L.Ed. 897 (1955). This Court should not consider the broad issues asserted by Petitioners until it is faced with a case which squarely places these issues into focus.

The Supreme Court of New Jersey correctly interpreted New Jersey's Medicaid program in a liberal sense, as it should have, with the assumption that if treatment or

services are rendered which are medically necessary for the health of a particular patient and such treatment or services are provided in the *only* available setting, then there can be no other finding except that Congress intended that all beneficiaries, under the above circumstances, be covered under Medicaid. Of course the petitioners dispute that the Supreme Court of New Jersey was correct in its liberal interpretation of New Jersey's Medicaid program. The petitioners inaccurately contend that in order for the State to keep the Medicaid program financially stable, it should be free to limit inpatient hospital Medicaid coverage based upon the type of "setting" in which care is received by a program beneficiary. As previously pointed out, if lesser care facilities were available, there is no question that the Medicaid program would have expended a substantial portion of the sums in question.

If the course of treatment received by a beneficiary does not fall within the technical and bureaucratic regulatory guidelines defining the level of care a beneficiary should receive in a particular setting, then coverage is denied regardless of the fact that the attending physician and the Utilization Review Committee certify that the treatment rendered was medically necessary for the patient's well-being. This, the petitioners contend is consistent with the federal law which governs New Jersey's Medicaid program.

The New Jersey Courts found that the present Medicaid matters did not involve the "misutilization" of hospital facilities but rather appropriate utilization, under the circumstances, as far as the welfare of the patients was concerned. This was consistent with the federal Medicaid requirements of all state plans and is necessary in light of Congress' intention of providing medical care to those who

might not otherwise receive it. The following provision found in the Medicaid Act clearly discloses the goals Congress envisioned when it established the joint federal and state, health care program:

> §1396 a
>
> (a) (19) A state plan for medical assistance must provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be *provided in a manner consistent with simplicity of administration and the best interests of the recipients.* (emphasis added)

D. *There is no conflict of authority regarding the issue of whether a provider must be reimbursed for services rendered to a patient while awaiting transfer to a lesser care facility*

There is no conflict among lower courts regarding the issue of whether a state should be required to reimburse a provider for moneys spent in providing care while the patients awaited placement in a lesser care facility. These reimbursements have been upheld in both Medicaid, *see Frankford Hosp. v. Commonwealth of Pa. Dep't of Public Welfare,* 26 Pa. Comm. 484, 364 A.2d 957 (1976); *Commonwealth of Pa. Dep't of Public Welfare v. Temple University,* 21 Pa. Comm. 162, 343 A.2d 701 (1975); *University of Utah Medical Center v. Bonneville County,* 93 Ida. 432, 529 P.2d 1304 (1974), and Medicare cases, *Hultzman v. Weinberger,* 495 F.2d 1276 (3d Cir. 1974); *Torphy v. Weinberger,* 384 F. Supp. 1117 (E.D. Wis. 1974); *Hayner v. Weinberger,* 382 F. Supp. 762, 765 (E.D.N.Y. 1974).

The federal concept of medical necessity is most clearly defined in those cases dealing with Medicare legislation.

42 U.S.C. §1395 *et seq.* The overwhelming majority of cases decided under this legislation hold that an individual who is eligible for extended care coverage does not lose all coverage under the Act during a period in which he is forced to remain in a general hospital for treatment simply because he is unable, without any fault of his own, to transfer to an extended care facility. See *Hayner v. Weinberger,* 382 F. Supp. 762, 765 (E.D.N.Y. 1974); *Hultzman v. Weinberger,* 495 F.2d 1276 (3d Cir. 1974); *Torphy v. Weinberger,* 384 F. Supp. 1117 (E.D. Wis. 1974). The decisive factor in these cases, in determining whether or not to extend coverage, was whether the services rendered were reasonable for the welfare of the patient, not whether the care constituted reasonable hospital service.

Respondent believes the same construction of the term "medically necessary" that has been given by courts in Medicare cases should be utilized in Medicaid cases. The Appellate Division of the Superior Court of New Jersey, in its decision in this case below, felt the same way:

> The Director's argument that the Medicare cases are not applicable in the Medicaid context raises a distinction without any real difference. The Medicare legislation, like the Medicaid legislation, seeks to encourage the efficient and economical use of medical facilities. Both have as their goal the availability of services *medically necessary* for patients eligible under the respective acts. The controlling factor is not *where* the service or treatment is performed but *whether* it is medically necessary. Under this factor there can be no "misutilization" if no lesser care facility is available.

App. B at 36a. Both the Appellate Division and the Supreme Court have determined that the services rendered

to the three patients involved were medically necessary and reasonable. The State's regulations which preclude a finding of medical necessity under these circumstances, thus making it impossible for the provider to render the continued needed care, conflict with the purposes of the Social Security Act and with the federal interpretation of when services are medically necessary.

CONCLUSION

The Respondent submits that a writ of certiorari should not be granted in this cause for the following reasons:

1. The Petitioners misconstrue the basis for the Supreme Court's narrow ruling and mistakenly assert that the case involves broad issues regarding the interpretation of statutory provisions of the Medicaid Act.

2. The Petitioner's brief is riddled with inaccuaries, which, under United States Supreme Court Rule 23(4), is sufficient reason for denying the petition.

3. The decision of the Supreme Court of New Jersey does not conflict with interpretations of the Medicaid Act that have been given by the Federal and State Courts.

4. There is no conflict of authority regarding the issue of whether a provider must be reimbursed for services rendered to a patient while awaiting transfer to a lesser care facility.

Respectfully submitted,

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Supreme Court, U. S.
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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1979
NO. 79-430

STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services the State of New Jersey, PETITIONERS

v.

MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey, RESPONDENT

AMICUS BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS AND THE STATES OF OHIO, NEW HAMPSHIRE, AND WYOMING IN SUPPORT OF THE STATE OF NEW JERSEY'S PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

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STATE OF NEW JERSEY; ANN KLEIN, Commissioner of the Department of Human Services of the State of New Jersey; and THOMAS M. RUSSO, Director of the Division of Medical Assistance and Health Services the State of New Jersey PETITIONERS

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MONMOUTH MEDICAL CENTER, a non-profit corporation of the State of New Jersey, RESPONDENT

AMICUS BRIEF OF THE COMMONWEALTH OF MASSACHUSETTS AND THE STATES OF OHIO, NEW HAMPSHIRE, AND WYOMING IN SUPPORT OF THE STATE OF NEW JERSEY'S PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

INTEREST OF THE AMICI

The Commonwealth of Massachusetts and the states of Ohio, New Hampshire, and Wyoming (the amici states) file this amicus brief in support of the State of New Jersey's petition for a writ of certiorari to the Supreme Court of New Jersey in the case of Monmouth Medical

Center v. State of New Jersey, 80 N.J. 299, 403 A.2d 487 (1979) (Monmouth). The amici states seek to express their concern that the Court not permit the structure and operation of the state-federal Medicaid program, in which they participate along with New Jersey, to be drastically and unwisely altered by judicial decision unsupported by statutory requirement. In particular, they seek to place the Supreme Court of New Jersey's decision in Monmouth in the context of other similar decisions of the state and federal courts and identify the shared elements of erroneous reasoning which have led to the imposition of unanticipated burdens and restrictions upon the participating states. As those who must bear these burdens and adjust to these restrictions, the amici states are perhaps uniquely qualified to convey these concerns to the Court.

SUMMARY OF ARGUMENT

In the first portion of their argument, the amici states collected and analyze recent cases under title XIX which, like Monmouth, impose considerable financial and administrative burdens upon the states. The amici states argue that these decisions, as does Monmouth, lack support in the statute. The amici states also argue that

these decisions, by disregarding established approaches to statutory interpretation and deferring insufficiently to state and agency discretion, severely disrupt the relationships between the states and the federal government. Finally, the amici states observe that Monmouth and cases similar to it exhibit a strong end-result orientation and that this orientation, however desirable as a matter of broad social policy, is an improper one for the federal and state courts to employ in deciding cases under title XIX.

The amici states dedicate the second portion of their argument to a review of title XIX's controversial "necessary medical services" language. The meaning of this phrase is critical to the Supreme Court of New Jersey's decision in Monmouth and the decisions of the lower federal courts in similar cases. What Congress meant by the phrase is also generally misunderstood. To demonstrate the fundamental nature of this misunderstanding and provide the Court with a basis for perceiving the phrase's proper interpretation, the amici states present a careful analysis of title XIX's legislative history. This analysis demonstrates that Congress did not use the phrase "necessary medical services" as a substitute for the term "medically necessary" services

and that title XIX does not require the states, as the court in Monmouth held, to reimburse health care providers for the costs of "medically necessary" health care.

ARGUMENT

I. The Nature Of The Problem

Must a state provide reimbursement for the costs of a particular "medically necessary" health care service under its Medicaid program? If so, why? These two questions embody the essence of a large and various class of cases with which the federal and state courts have been required to deal since this Court's decision in Beal v. Doe, 432 U.S. 438 (1977). In Beal, this Court held that title XIX of the Social Security Act does not impose upon states which choose to participate in the cooperative federal-state program of medical assistance which it authorizes an obligation to reimburse health care providers for the costs of "elective" health care services not included in a state's approved plan for medical assistance. In reaching this conclusion, the Court, as it had in earlier A.F.D.C. cases,[1/] stressed that the ques-

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1/ E.g., Burns v. Alcala, 420 U.S. 575 (1975).

tion involved was one of statutory interpretation and set forth an analytical model which, one might have supposed, lower courts would recognize as the one to use when called upon to resolve similar controversies. Unfortunately, with a few encouraging exceptions, the federal and state courts have failed to adopt this Court's approach to the interpretation of title XIX's provisions and, instead, reached decisions imposing requirements upon the states which lack support in the statute's provisions and any resemblance to the analytical methodology used in Beal. More than the results in individual cases, it is the lower courts' failure to understand and accept the Beal methodology[2/] which has led to the significant adverse judicial alterations of the

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[2/] While Beal's status as a model of analysis is well-deserved, it does contain an unfortunate element of commentary which is largely responsible for the present controversy over "medically necessary" services. The troublesome dictum appears near the end of the Court's analysis of the statutory issue: "Although serious statutory questions might be presented if a state medicaid

national Medicaid program[3/] of which Monmouth is a glaring instance. A few examples of the reasoning pro-

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[2/] continued

plan excluded medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary — though perhaps desirable — medical services... [emphasis supplied and in the original]."

This dictum has led many lower courts to assume an admittedly serious question has an even more serious answer, i.e., that title XIX does require states to pay for "medically necessary" services. Recognizing the limitations of this brief in support of New Jersey's petition for certiorari, the amici states argue in an abbreviated form in section two that this conclusion is a most serious mistake. Should the Court have a similar perception, the amici states are prepared to detail their view in an amicus brief on the merits.

[3/] A compendium of these cases appears as Appendix A to this brief.

cesses which the lower courts have used instead of the approach embodied in Beal may help to make these observations concrete, and the opinion of the Supreme Court of New Jersey in this case provides a logicial starting point for this survey.

The Supreme Court of New Jersey based its holding in Monmouth upon a determination that the state's restrictions on hospital reimbursement for services rendered to patients who might equally well be cared for in a less expensive facility were a bed available, e.g., a nursing home, are unreasonable and therefore invalid under title XIX. 80 N. J. 299, 309-11, 403 A.2d 487, 492-93. After discussing various policy considerations, the court below reached its conclusion in a single sentence: "Nevertheless, in order not to transcend the Federal Act, the Division must exercise discretion so as to allow reimbursement where medically necessary care has been rendered to an unavoidably retained patient." Id.; 403 A.2d at 493. This conclusion, unadorned by citation to statutory or decisional law and uninformed, apparently, by a review of the Social Security Act's legis-

lative history,[4] at once imposes upon the State of New Jersey and the United States an additional financial burden which New Jersey estimates may amount to as much as 37 million dollars.[5]

Unlike Beal, where this Court observed that title XIX "makes no reference to abortions, or, for that matter, to any other particular medical procedure...," that the statute "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act [footnote omitted, emphasis supplied]," and therefore concluded that title XIX does not require the states to provide

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4/ See pages 26-41, below.

5/ This figure represents the State of New Jersey's estimate of its additional expenses, nineteen million dollars, and the United States's equal additional contribution. See Petition for Certiorari at 20.

reimbursement for the costs of elective abortions, the court below was content to rely upon broad policy arguments to justify its conclusion that New Jersey is required to reimburse hospitals for the costs of acute care services delivered to patients who do not need them. See, e.g., 80 N.J. at 310-13, 403 A.2d at 492-94. The fact that the court summarizes its conclusion in terms of "reasonableness" does not alter its essential nature as nothing more than a substituted judgment, on public policy grounds, of issues and considerations which the state and federal administrative agencies charged with responsibility for administering the Medicaid program in New Jersey have assessed differently.[6/]

6/ Although the court says that its considers the state's rule "unreasonable," its argument demonstrates at most that reasonable minds may disagree. Such disagreements are not equivalent to the prohibition of "irrationality" which title XIX, under Beal, imposes upon the states.

The transsexual cases, in particular Rush v. Parham, 440 F. Supp. 383 (N.D.Ga. 1977), app. pending sub nom. Rush v. Poythress, No. 77-2743 (5th Cir.), present even more disturbing examples of the lower federal courts' disregard of the the proper and established approach to the interpretation of the Social Security Act.[7/] The issue in transsexual cases, speaking generally, is whether state plans for medical assistance under title XIX must reimburse hospitals and surgeons for the costs of providing sex change operations to eligible Medicaid recipients. In their strongest formulation, these cases present a claim that, although either explicitly or inferentially excluded from coverage under a particular

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7/ While it is true that Rush was decided several months after Beal and, indeed, relies heavily upon Beal's dictum, it might be unfair to hold the district court to a full appreciation of a virtually contemporaneous decision. However, Beal's methodology has a undeniably venerable lineage. E.g., Burns v. Alcala 420 U.S. 575 (1975); King v. Smith, 392 U.S. 309 (1968).

state plan, a state must provide reimbursement to providers of transsexual surgery services because such services are "medically necessary." E.g., Rush v. Parham, supra, at 389. In Parham, the district court reached its determination that "medically necessary" services "are the irreducible minimum coverage which states must provide..." on the basis of four remote and inferentially weak premises: first, this Court's dictum in Beal; second, the authorization of appropriations language in §1396; third, a definition of the phrase "medically needy"; and, fourth, a reference in regulations to acceptable bases for limiting the "scope, amount, and duration of benefits...." The significant aspect of this approach to decision making under title XIX is that it represents a precise inversion of the Beal methodology. That is, although lacking any concrete statutory basis for its conclusion that states must provide reimbursement for all "medically necessary" services, the court inferred the requirement and imposed it upon the State of Georgia. Surely, as in Beal, the result should have been exactly the opposite: if the statute does not explicitly require a state to provide reimbursement, the federal courts should not

do so. See Quern v. Mandley, U.S. , 98 S. Ct. 2068, 2077-78 (1978) (Stewart, J.)("But Congress' choice of precise language in this complex statute cannot be glossed over with such generalities..."); Burns v. Alcala, 420 U.S. 575, 577-80 (1975) (Powell, J.). At the very least, weak inferences of legislative intent, unsupported by substantial extrinsic evidence, should not be the basis for broad conclusions which fundamentally alter the structure and operation of a national welfare program.[8/]

Appreciation of another line of cases, symptomatic of the same methodological problems but occurring in a

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[8/] There is no doubt that imposition of a "medically necessary" requirement would work such changes. For example, it is well known that, ever since title XIX's inception, HEW has approved state plans for medical assistance which have excluded whole categories of services or limited their amount, scope, and duration in significant ways. See 2 CCH Medicare and Medicaid Guide, ¶¶ 15,501-15,660 (providing tables by state of approved state plan program components). Under cases such as Rush, HEW's action would be set aside if the excluded or limited services are considered "medically necessary."

constitutional context, begins with the Third Circuit's decision in Klein v. Califano, 586 F.2d. 250, an en banc decision affirming the District of New Jersey's determination in Klein v. Mathews, 430 F. Supp. 1005 (D.N.J. 1977). Klein, and others which have followed it,[9/] are cases involving claims that title XIX requires participating states and HEW to provide reimbursement pending notice and hearing to nursing homes which do not meet statutory standards because to deny reimbursement would be tantamount to depriving Medicaid recipients of their constitutionally protected expectation

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9/ E.g., Town Court Nursing Center, Inc. v. Beal, 586 F.2d 280 (3rd Cir. 1978), cert. granted sub nom. O'Bannon v. Town Court Nursing Center, Inc. 47 U.S.L.W. 3683 (April 6, 1979); Bracco v. Lackner, 462 F. Supp. 436 (N.D.Calif. 1978) (preliminary injunction); Newfield House, Inc. v. Commonwealth of Massachusetts, Civil Action No. 76-3742-G (complaint filed September 30, 1976) (pending on motions to dismiss and for partial summary judgment).

"to continued residency at the home of one's choice absent specific cause for transfer..." without due process. Klein, supra, at 258. In these cases, the lower federal courts have once again been willing to infer broad and burdensome requirements on the basis of immaterial or, at best, tangentially related statutory provisions. Not surprisingly, their reasoning is disjointed and unconvincing.[10/] The approach is nonetheless infectious, and,

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10/ Chief Judge Seitz's dissent in Town Court Nursing Center, Inc. v. Beal, supra, observes how unsatisfactory the Third Circuit's analyses in Klein and Town Court are:

> The majority finds that continued residence in the nursing home of one's choice absent specific cause for transfer is an underlying substantive interest created by three Mediciad provisions. Under the first, 42 U.S.C. §1396a(a)(23), a Medicaid recipient may obtain medical care "from any institution...qualified to perform the service or services required." Clearly, what the majority characterizes as a recipient's right to obtain medical care from a "freely

unless this Court administers an effective cure,

10/ continued

selected provider is limited to a choice among institutions which have been determined by the Secretary to be "qualified." Next, the majority's reliance on 45 C.F.R. § 205.10(a)(5), ensuring a notice and hearing to a recipient whose benefits are suspended, reduced, discontinued, or terminated, is obviously misplaced. As the majority itself notes, the decertification of these facilities did not reduce or suspend the residents' rights to continued benefits.

Finally, the majority relies upon 45 C.F.R. § 249.12(a)(1)(ii)(B)(4), which establishes as one requirement for an institution's certification that each resident admitted to that institution be "transferred or discharged only for medical reasons or for his welfare or

may reach epidemic proportions.11/

10/ continued

that of other patients, or for nonpayment for his stay." The majority reads this provision as a limitation on the Secretary's power to interrupt a recipient's residence at a particular institution. Clearly, however, this provision is a standard of conduct imposed by the Secretary upon the provider. Violation of this standard is one of the many grounds for decertifying the offending institution. See 45 C.F.R. §§ 249.33(a)(2), 249.10(b)(15). The provision creates no "substantive interest" in the residents vis-a-vis the Secretary. Town Court at 295-96.

11/ E.g., Bracco v. Lackner, 462 F. Supp. 436, 450, 452 (N.D.Cal. 1978) (preliminary injunction). Acceptance by such an important district demonstrates the appeal of the result in Klein and the uphill fight states must wage in light of the Third Circuit's ipse dixit approach to the interpretation of title XIX.

Mention of one final set of cases completes the survey. Following this Court's decision in Beal, litigation has developed across the country challenging state and federal restrictions on the reimbursement of "medically necessary" surgical services provided in connection with the performance of abortions. Currently, although the majority of district courts which have considered the question have held such restrictions impermissible under title XIX, two Courts of Appeals, those for the First and Seventh Circuits, have found persuasive the states' arguments that title XIX does not require reimbursement of all "medically necessary" services. Preterm v. Dukakis, 591 F.2d 121, 124-25 (1st Cir. 1979); Zbaraz v. Quern, 596 F.2d (7th Cir. 1979). However, while avoiding the precise error which the Supreme Court of New Jersey in Monmouth and the district court in Rush v. Parham, supra, commit, the First and Seventh Circuits, still content to skim the surface in their analyses of title XIX's requirements, held that it is " 'unreasonable' and 'wholly [in] consistent with the objectives of the Act,' 42 U.S.C. § 1396a(a)(17), for a state to provide abortion services and then, with limited exceptions for victims of rape and incest, deny it to all those who will not die without it."

Preterm v. Dukakis, supra at 126; accord, Zbaraz v. Quern, supra at 199. Why this is so, and particularly why it is so as a matter for which the abstract intellectual reasoning of a court is an acceptable substitute for deferential analysis of Congressional intent and HEW administrative action, the Courts of Appeals do not say.[12/] Indeed, they apparently feel no compulsion to do more than express their incredulity. See, e.g., Preterm at 126. But, of course, Beal establishes that the views of the Congress and HEW, not those of a federal court, are the standard against which courts should judge the conformity of state plans for medical assistance with the

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12/ That Congress did not intend the provisions of § 1396a(a)(17) to provide the basis for the federal courts' substituting their judgments of rational approaches to providing medical assistance for the decisions of state agencies and HEW is suggested in section two. Full argument on this point is deferred to briefing on the merits.

requirements of title XIX. Preterm and Zbaraz, as do Monmouth, Parham, and Klein, simply ignore the Beal methodology.

It is hard to resist observing at the end of this survey that the cases just discussed exhibit a strong end-result orientation. Judicial concern with results is not itself controversial, for in many cases, particularly those involving private litigants, it is the result which counts. But public law cases such as those just surveyed present a different problem. This type of litigation is an aspect of the process of government, and the process itself is therefore often more important than its results. Without denying the importance of society's caring responsibly for its aged and infirm and others too poor to obtain necessary health care services, the amici states submit that cases like Monmouth, Parham, Klein, and Preterm are objectionable primarily because their inadequate decision making methodology leads to the development of rules of law which, as the following discussion demonstrates, are contrary to those the Congress has formulated.

II. Title XIX Does Not Require Participating States To Provide Reimbursement For The Costs Of Any Particular "Medically Necessary" Service.

A. Introduction

Proper interpretation of the Social Security Act depends upon careful observation of its architecture. Although Congress has amended the statute often and substantially since its passage in 1935, its basic structure has exhibited remarkable endurance. Title XIX of the Act, codified as Chapter XII, subchapter XIX §§ 1396a - 1396k of the United States Code, follows closely the now classic style of the Act's draftsmen: Section 1901 (codified as 42 U.S.C. § 1396 (1976)) constitutes an appropriations authorization and embodies a subsidiary statement of purpose; section 1902 (codified as 42 U.S.C. § 1396a (1976)) establishes state plan requirements and directs the Secretary of Health, Education, and Welfare to approve plans which meet these requirements; section 1903 (codified as 43 U.S.C. § 1396b (1976)) requires the Secretary to reimburse states for certain portions of their expenditures "as medical assistance"; section 1904

(codified as 42 U.S.C. § 1396c (1976)) authorizes the Secretary of HEW to suspend payments after notice and hearing (the so-called "conformity hearing") upon a determination that a state has affected unlawful modifications in its state plan or has failed to administer it in substantial compliance with the state plan requirements contained in § 1902; section 1905 (codified as 42 U.S.C. § 1396d (1976)) provides definitions of selected terms, including and of particular importance for present purposes, "medical assistance"; and the remaining sections deal with miscellaneous matters, including criminal penalties for fraudulent claims, the certification of skilled nursing home facilities, and similar specific aspects of the Medicaid program.[13/]

Section 1901 provides, as it did when originally enacted in 1965, that:

> For the purpose of enabling each State as far

13/ A common short-hand way of referring to the major or original sections of the Act when one is concerned with their function regardless of the programmatic title in which they appear is by their last

> as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled[14/] individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for

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13/ continued

two digits (the first digit merely identifies the title). Thus, whatever the title, §§ 102, 402, etc. (the state plan requirements sections) are referred to as the "02" sections; §§ 103, 403, etc. (the payments to the states sections) as the "03" sections; and §§ 104, 404, etc. (the conformity hearing sections) as the "04" sections. The amici states also use this method of reference occasionally in this portion of their brief.

14/ 87 Stat. 960 substituted the term "disabled" for the phrase "permanently and totally disabled."

> independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

Four features of this section merit close attention. First, it is primarily an appropriations authorization and subsidiary statement of purpose section. Second, the section in terms imposes no substantive requirements upon the states. Rather, in its only sentence which can fairly be considered prescriptive, it simply restricts the use of the funds it authorizes to be appropriated each fiscal year to the making of payments to those states which have submitted "plans for medical assistance" to the Secretary of HEW and obtained the requisite approval of them. Third, as do the cognate sections of its predecessors and successors,[15/] the sectión begins with a

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15/ E.g., titles I and XX.

statement of purpose which announces Congress's intention as being to "[enable] each State, as far as practicable under the conditions in such state, to furnish...[emphasis supplied]" a certain type of public assistance ("medical assistance") to certain persons. Recognition of the financial limitations of state governments is clearly this language's purpose. Fourth and perhaps most importantly, the section never uses the phrase "medically necessary." Congress's omission of any reference to this concept in the design and construction of this section is, as the amici states argue later, quite intentional, and judicial attempts to conflate the phrase "necessary medical services" with the term "medically necessary" not only lack textual support but also do violence to the statute's architecture.

Section 1901 has two—and only two—functions to perform as a component of title XIX, and Congress designed it to perform these functions in concert with three other sections: 1902, 1903, and 1905. The first function is to operate as a standing authorization for appropriations. It performs this function in conjunction with §1903 which requires the Secretary to pay each state with an approved plan from appropriated funds "an amount equal to the Federal medical assistance percentage

(as defined in section 1905(b), subject to subsections (g), (e), and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan. . . ."

The second function is to limit the use of appropriated funds to the reimbursement of only those state expenditures incurred as "medical assistance provided to eligible persons." Since "medical assistance" is a defined term, see §1905(a), analysis of the relationship between the "01" section and its mention of "necessary medical services" and the definition contained in the "05" section requires a somewhat lengthy digression.

B. Federal Financial Participation in State Expenditures for Health Services Prior to the Enactment of Title XIX

Title XIX, enacted in 1965, created a separate system for providing medical assistance benefits to persons who previously received such benefits as a function of their eligibility for the more traditional form of public assistance: cash grants. For example, under title I (originally Old-Age Assistance (OAA)), federal financial participation was available to states in "an

amount, which shall be used exclusively as old-age assistance, equal to one-half of the total of sums expended. . . as old-age assistance under the State plan. . . ." 49 Stat. 621, § 3(a). This traditional cash grant form of public assistance was expanded in 1956 to include "medical assistance" and a medical "vendor payments" program. Although states had previously been able to assist OAA recipients in meeting medical expenses and obtain federal financial participation in the expenditures they incurred, they had been limited to providing this assistance as part of the monthly OAA cash grant, and rather low limits were placed on the maximum amount of a cash grant. As the Senate Finance Committee noted:

> The bill would provide Federal matching of expenditures for payments to suppliers [vendors] of medical care separate from money payments to assistance recipients and would use an average basis for determining Federal participation in payment to suppliers of medical care. . . . This assurance of Federal participation on an average basis should <u>stimulate</u> States to secure <u>necessary</u> care for recipients, particularly in States with relatively limited resources. . . . Under the bill all payments

> to suppliers of medical care would be matched under the separate provision. States would still be able if they chose to do so to include in money payments to recipients amounts to meet medical needs within the maximums on money payments specified in titles I, IV, X, and XIV [emphasis supplied].
> Sen. Rep. No. 2133, 84th Cong., 2nd Sess., July 26, 1956, reprinted in 3 U.S. Code Cong. & Admin. News 3877, 3905-06 (1956).

Two specific points are worth making at this juncture. First, the Congress, as it usually does when it improves the Social Security Act, expressed its intention in terms of "stimulating" — not requiring — the states to increase their expenditures for public assistance and recognized that, given the fiscal limitations of state governments, the most effective form of stimulation is increased federal financial participation. Second, this is the first time that the word "necessary" appears, as far as the amici states are aware, in conjunction with a discussion of medical care benefits. Significantly, the word does not appear in the 1956 amendments themselves.

Moving forward in time, the Social Security

Amendments of 1960 worked the penultimate significant change in Congress's approach to authorizing federal financial participation in state expenditures for medical care under their public assistance programs. Often referred to in part as the Kerr-Mills Act, portions of the 1960 Amendments were the predecessor of title XVIII (Medicare) and, as events unfolded, title XIX as well. Noting that "[t]he major issue presented to the [Senate Finance Committee] this year has been the increasing cost of adequate medical care for older people. . .," the Senate Finance Committee proposed substantial changes in the House bill, HR. 12580. For present purposes, the most significant change was to provide for the amendment of title I to include "medical services for the aged," and the most illuminating aspect of these amendments is the legislative history associated with the introduction of the phrase "necessary medical services." As a review of this material demonstrates, the lower federal courts and the Supreme Court of New Jersey in Monmouth have erred in reasoning that Congress used the phrase "necessary medical services" as an equivalent for the term "medically necessary" in title XIX. To the contrary, when it used the phrase "necessary medical services" for the first time in 1960, Congress had a completely different concept and purpose in mind.

The Senate Finance Committe's report accompanying the 1960 Amendments and referring specifically to the Kerr-Mills Act amendments to title I of the Act begins its analysis with the following instructive paragraph:

> Your committee has designed a Federal-State matching program based upon historic principles of Federal-State cooperation. This program is established under title I of the Social Security Act, thereby providing additional matching funds to the States to (1) establish a new or improve their existing medical care program for those on the old-age assistance roles, and (2) add a new program designed to furnish medical assistance to those needy elderly citizens who are not eligible for old-age assistance but who are financially unable to pay for the medical and hospital care needed to preserve their health and prolong their life. The twofold plan would thus cover all medically needy aged 65 or over, whether or not they are eligible for old-age assistance, or whether or not they are eligible for the benefits under the social security or any other

> retirement program. It accomplishes this objective within the framework of a Federal-State program with broad discrimination allowed to the States as to the programs they will institute, improve, and administer in meeting the health needs of the aged when illness occurs or continues [emphasis supplied].16/

Sen. Rep. No. 1856, 86th Cong. 2nd Sess. (1960), reprinted in 2 U.S. Code Cong. & Admin. News 3608, 3610 (1960).

16/ The report contains a further and more explicit statement of purpose which is also worth reading:

> 1. Purpose
>
> The existing provisions of title I provide Federal funds to the States for medical services to aged individuals who are determined to be needy by the States. At the present time, States provide needy aged persons with "money payments" for medical

The report continues with a description of title I's

16/ continued

services and also provide "vendor payments" to the suppliers of medical care. . . . These provisions vary greatly. Some States have relatively adequate provisions for the medical care of needy persons; others have little or no provision. The increased Federal financial provisions in the bill are designed to encourage the States to extend comprehensive medical services to all needy persons receiving monthly assistance payments. Participation in the Federal-State program is completely optional with the States, with each State determining the extent and character of its own program, including the standards of eligibility and the nature and scope of benefits. The limits of Federal financial participation are discussed later in this report [emphasis supplied].

operation prior to amendment and the changes which the Committee intended to make in it. Although too lengthy to reproduce in their entirety here, certain sections deserve explicit mention. The report makes clear that Congress's intention was to "encourage," not require, the states to enlarge their expenditures for medical care services provided to persons receiving OAA or who, while able to meet the day to day expenses of life, are unable to incur susbtantial expenditures for medical services (the "medically needy"). While the Congressional goal was to encourage the development of "comprehensive medical care program[s]" for OAA recipients, the Senate Financial Committee deliberately wrote that, as to the scope of medical services the states might provide and still secure federal financial participation in their OAA expenditures, "[t]here is no Federal limitation on medical services provided under the bill. Each State may determine for itself the scope of medical services to be provided in its program." Similarly, as to the "medically needy" and the new Medical Assistance for the Aged (MAA) program, the Committee emphasized the incentive nature of its proposal and its intention that the states:

have broad latitude in determining eligibility for benefits under the program as well as the scope and nature of the services to be provided within the limitations prescribed. Thus, each State would determine the tests for eligibility and the medical services to be provided under the State program within the limitations described below. Federal financial participation would be governed by the establishment of an approved plan subject to the criteria and limitations prescribed in the law [emphasis supplied].

The limitations upon federal financial participation to which the Committee referred are listed in the immediately following section of the report which deals with eligibility:

> 2. Eligibility
> Benefits under a State program may be provided only for persons 65 years of age or over to the extent they are unable to pay the cost of their medical expenses. . . [emphasis supplied].

And then the Committee indicated exactly how it proposed to amend title I to accomplish its goals:

> Section 1 of the Social Security Act, as it would be amended by the bill, provides that one of the objectives of the title is to furnish medical assistance to individuals who are not recipients of old-age assistance but whose income and resources are insufficient to meet the costs of necessary medical services. . . [emphasis supplied].[17/]

Here, then, are the roots of the phrase "necessary medical services" which the lower federal courts and the court in Monmouth equate with the term "medically necessary." These roots rest not in the "02" plan requirements section of title I, but rather in the "01"

17/ The Conference Committee adopted the Senate Finance Committee's approach and its choice of the phrase "necessary medical services." Conf. Rep. No. 2165, 86th Cong, 2nd Sess. (1960), reprinted in 2 U.S. Code Cong. & Admin. News 3749, 3756 (1960).

authorization section. They are nurtured not by a Congressional intention to require the States to provide any medical services at all, "medically necessary" or otherwise, but rather by a desire to limit the availability of MAA program benefits to those medically needy aged persons "whose income and resources are insufficient to meet the cost of necessary medical services [emphasis supplied]." Unless the Congress substantially altered its intentions between 1960 and 1965 concerning the federal-state public assistance programs and their medical services components which it created under the Act, the amici states submit that it should be clear that the phrase "necessary medical services," and the legal purposes it was intended to serve, are not equivalent — indeed, have nothing in common with — the term "medically necessary". The following discussion both brings this digression to a conclusion and demonstrates that the Congress made no such change in its intentions when it enacted title XIX.

C. The Enactment of Title XIX

Title XIX was enacted as a component of the Social Security Amendments of 1965, 79 Stat. 286. Title XVIII, which created the Medicare program, was the major provision of this set of amendments to the Act, and the

controversial nature of this initial national foray into health insurance overshadowed the issues involved in the drafting of title XIX. This result is understandable for, as the Congress conceived it, title XIX was simply a consolidation and improvement of the existing medical assistance programs already authorized under the Act's various categorical assistance titles. The Senate Finance Committee's Report makes this point clear:

6. BACKGROUND AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical

care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of needy aged, bline, disabled, and dependent children — the so-called vendor payments.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs [i.e., "necessary medical services"]....

The committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, the committee bill would establish,

> effective January 1, 1966, a new title in the Social Security Act — "Title XIX: Grants to the States for Medical Assistance Programs." Sen. Rept. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1 U.S. Code Cong. & Admin. News 1943, 2014.[18/]

The Senate report then goes on at some length and in fair detail to describe the general nature of its proposals for title XIX and, in a section by section analysis, the effect of the proposal's specific provisions. See Sen. Rept. 404, 89th Cong., 1st Sess. (1965), reprinted in U.S. Code Cong. &

18/ The introductory summary of the proposed title XIX put the matter even more simply:

> In order to provide a more effective Kerr-Mills medical assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate medical care program to consolidate and expand the differing provisions for the needy which currently are found in five titles of the Social Security Act.

Admin. News, 2015-52 (1965). Three observations are worth making concerning the report's contents. First, it specifically discusses suggested state plan requirements for inclusion in the "02" section of the new title. Second, neither in its discussion of plan requirements nor anywhere else does the report mention the term "medically necessary" or suggest that the Senate Finance Committee intended to require the States to provide any specific type of medical services. Rather, as stated in the paragraphs dealing with eligibility and in reference to the "02" section requirements, the committee spoke only in terms of requiring states to include in their state plans "provision for medical assistance [to the categorically eligible and, if desired, the "medically needy"]," id. at 2017; see also 2144-45. Third, §1901 was taken, with appropriate adjustments to make its provisions applicable to all of the Act's categorical assistance titles, from §101, as amended by the Kerr-Mills Act in 1960. See id. at 2144.

And so, there it is. The relationship between "necessary medical services" and the defined term "medical assistance," the relationship which prompted this extended digression, now appears to be a straight-forward one. "Necessary medical services" is the phrase, inherited

from Kerr-Mills, which the Congress used first in Kerr-Mills and then in title XIX both to (1) expand the availability of federal financial participation beyond the categorically needy to the medically needy and (2) limit the federal obligation to participate in state expenditures to those incurred as "medical assistance" on behalf of persons "whose income and resources are insufficient to meet the costs of necessary medical services...[emphasis supplied]." "Medical assistance," defined as usual in the "05" section of the new title, imposes the substantive requirement through its use, as usual, in the "02" section. Neither phrase has anything to do with the concept to which the term "medically necessary" refers.

D. The Use of the Defined Term "Medical Assistance"

Observation of title XIX's architecture reasonably concludes with a moment's look at the detailing associated with the placement and use of the defined term "medical assistance." As it appears in the "05" section, the definition of "medical assistance" contains no mention of "medically necessary" health care services.

Indeed, it mentions no specific type of health care service or characteristic of a health care service. Rather, it refers to broad classes or categories of health care and services and defines "medical assistance" to mean "payment of all or part of the cost of the following care or services... [emphasis supplied]." This choice of form, as with most good modern architecture, is based upon a clear perception of function:[19/] to describe the type of state expenditure in which the federal government would be willing to participate while leaving to the states broad discretion to determine the exact nature of the benefits to provide eligible recipients.

E. Summary

Title XIX's structural lines have not changed significantly since Congress shaped them in 1965. While both

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19/ See generally L. Sullivan, The Tall Office Building Artistically Considered, Lippencott's Magazine (March, 1896) (containing the statement thought to guide modern architecture that "Form ever follows function").

Congress and the Department of Health, Education, and Welfare have made substantial additions to the basic structure over the past fourteen years, most noticeably in the areas of cost control and facility and service standards, the amici states have found no indication of an intention to alter the title's fundamental design principles, principles which rest upon the foundation which the Act erected in 1935: (1) a federal-state cooperative system of financial participation in state expenditures for public assistance which (2) recognizes the historic and primary role of the states in the social welfare area and (3) seeks to stimulate and encourage the improvement of state welfare programs by making federal financial participation available to states which (4) submit plans for public assistance programs to the Secretary of HEW which satisfy the Act's requirements. A well-designed statutory scheme such as this cannot reasonably be thought to have omitted from careful and explicit statement such an essential requirement as the Supreme Court of New Jersey in Monmouth and the lower federal courts in similiar cases have added to it.

CONCLUSION

The Court should grant the State of New Jersey's petition for certiorari in this case. Doing so would give it the opportunity to complete the examination of the issues which Town Court Nursing Home v. Beal, 586 F.2d 280 (3rd Cir. 1978), cert. granted sub nom. O'Bannon v. Town Court Nursing Center, Inc., 47 U.S.L.W. 3683 (April 6, 1979), has brought to its attention and to terminate a controversy which has adversely affected the administration of the national Medicaid program in areas as diverse as nursing home services and abortion surgery. It would also permit the Court to analyze the substantive issue of statutory interpretation, whether state plans for medical assistance must provide reimbursement for particular "medically necessary" services, in an environment free of the "unique" considerations, Bellotti v. Baird, U.S. , 61 L. Ed.2d 797, 818 (1979), associated with cases like Preterm and Zbaraz. Finally, this case offers an opportunity, perhaps more appropriate than that which Town Court presents, to establish once and for all the approach which the lower federal courts should use in evaluating claims of state obligation under title XIX of the Social Security Act.

For all of these reasons, then, the amici states urge the Court to accept this case for plenary consideration and issue a writ of certiorari to the Supreme Court of New Jersey to review its judgment in the case of Monmouth Medical Center v. State of New Jersey.

Respectfully submitted,

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APPENDIX A

COMPENDIUM OF RELATED CASES DECIDED UNDER TITLE XIX

I. CASES DISCUSSING WHETHER MEDICAID REQUIRES FUNDING OF MEDICALLY NECESSARY SERVICES.

A. Transsexual Cases

Doe v. State Department of Public Welfare
257 N.W.2d 816, 819 (Minn. 1977)

State of Minnesota denied Medicaid benefits to recipient for transsexual surgery. Court held state regulation violated federal law because it denied medically necessary services solely because of the diagnosis, type of illness or condition, in violation of 45 C.F.R. §249.10(5)(i). If operation medically necessary, funding could not be denied.

Pinneke v. Preisser
U.S. District Court (N.D. Iowa) No. C77-3023,
May 11, 1979

Challenge to Iowa's policy of denying Medicaid benefits for transsexual surgery. Court held that where operation is medically necessary, it is contrary to provisions of Title XIX to deny coverage under Medicaid; Title XIX requires states to provide certain services,

42 U.S.C. §1396a(a)(13)(B), and, within these categories, states have no discretion to deny coverage for medically necessary services.

Rush v. Parham,
440 F. Supp. 383 (N.D. Ga. 1977), app. pending sub nom. Rush v. Poythress, No. 77-2743 (5th Cir.)
argued September 29, 1979

Plaintiff, a Medicaid recipient, sought declaratory, injunctive and mandamus relief for improper denial of Medicaid reimbursement for transsexual surgery expenses. Court found operation medically necessary and held that benefits for medically necessary service are not the only Medicaid coverage which states may provide eligible recipients but they are the "irreducible minimum coverage which states must provide..."

B. Abortion Cases

D.R. v. Mitchell
456 F.Supp. 609 (D.Utah 1978)

Claim for injunctive and declaratory relief that Utah statute limiting abortion funding to those cases where life of mother endangered in conflict with Title XIX. Court held that Medicaid law does not require funding of all medically necessary abortions— discusses meaning of

"necessary medical services;" decides that Title XIX may not require the funding of any class of abortions, and, if it does require funding of some abortions, it requires the subsidizing of only those abortions lawful in most states when Title XIX was enacted. Summary judgment for defendants.

Doe v. Busbee
U.S. District Court (N.D. Ga.) No. C76-786A,
June 5, 1979

Georgia statute which limits funding of abortions to life-threatening situations and victims of rape or incest inconsistent with Title XIX which requires coverage for all medically necessary services within the mandated categories for categorically needy. Preliminary injunction entered enjoining state from refusing to provide reimbursement for medically necessary abortions for named plaintiffs.

Doe v. Kenley
584 F.2d 1362 (4th Cir. 1978)

State of Virginia wanted to eliminate Medicaid funding of non-therapeutic abortions; did so by requiring a physician to certify that mother's life would be endangered if abortion not performed, in order to obtain payment by state. District Court dismissed class action and Court of Appeals reversed and remanded,

saying policy could not be used to implement state's objective. Court did not reach statutory (Title XIX) or constitutional (equal protection; due process) issues; struck down on basis that policy is ambiguous — if aim is to stop payment for non-therapeutic abortions, payment for those which are life-threatening only, rather than health-threatening, not consistent with stated objective. Ambiguity violates §1396(a)(17) of Title XIX. Court's discussion implicitly accepts the premise that state must pay for medically necessary abortions.

Emma G. v. Edwards

434 F.Supp. 1048 (E.D.La. 1977), app. pending,
No. 79-1144 (5th Cir.)

Suit to enjoin Louisiana Health and Resources Administration from denying Medicaid payments for therapeutic abortions performed outside hospital and to enjoin State Board of Medical Examiners from enforcing state statute requiring all abortions to be performed in licensed hospital. Court accepted stipulation entered by the parties that state funded all medically necessary abortions and added that it would be required to do so under Maher and Beal.

Planned Parenthood Affiliates of Ohio v. Rhodes

C-2-79-687 (E.D. Ohio 1979)

Plaintiffs sought injunction against state officials barring implementation of Ohio statute which restricted state-funded abortions to those where life of mother endangered, or to pregnancies resulting from rape or incest, when certain reporting conditions are met. Court held that Title XIX requires funding of all medically necessary abortions; refused to accept the narrower holding of Preterm, Inc. v. Dukakis and other cases which find that the Hyde Amendment impliedly repeals Title XIX to require state funding of only those abortions for which federal funds have been appropriated by the Amendment. Injunction enetered barring state defendants from refusing to fund all medically necessary abortions for eligible Medicaid recipients.

Preterm, Inc. v. Dukakis

591 F.2d 121 (lst Cir. 1979)

On application for preliminary injunction, District Court had held that Massachusetts statute which prohibits payment for all abortions except those necessary to prevent death of mother unduly restrictive and in conflict with Title XIX; the purpose of Title XIX is to provide necessary medical services and medical service like abortion which physician deems "necessary" for a

Medicaid recipient must be publicly funded. 463 F.Supp. 222 (D.Mass. 1978). On appeal, First Circuit found that the language of Title XIX does not require funding of all medically necessary services, but that the restriction embodied in the Massachusetts statute nonetheless violated Title XIX because it is " 'unreasonable' and 'wholly [in] consistent with objectives of the Act,' 42 U.S.C. §1396a(a)(17), for a state to provide abortion services and then... deny it to all those who will not die without it."

Roe v. Casey

464 F.Supp. 487 (E.D. Pa. 1978)

Challenge to restriction contained in state statute prohibiting state funding of abortions except where necessary to save mother's life. Court held statute discriminated arbitrarily against medically necessary abortions on basis of diagnosis, type of illness or condition involved, in violation of Title XIX. Held that Title XIX requires participating states to provide all medically necessary services, including medically necessary abortions, to eligible recipients, and that plaintiff had a right to receive reimbursement under Title XIX for medically necessary procedures. Order entered granting permanent injunctive and declaratory relief.

Zbaraz v. Quern

596 F. 2d 196 (7th Cir. 1979)

Action to enjoin 1977 Illinois statute which withdrew state funding for all abortions except those necessary to preserve the life of the woman. District Court initially abstained, which order was reversed, 572 F.2d 582. District Court then held that Title XIX required funding of all medically necessary abortions. Court of Appeals held that Hyde Amendment amends Title XIX and limits what state must pay for under Medicaid. Essentially said that it agreed with 1st Circuit opinion in Preterm, Inc. v. Dukakis, that Title XIX does not require states to fund all medically necessary services, but found this limitation discriminatory on the basis of condition, in violation of 45 C.F.R. §449.10(a)(5)(i). Remanded with order to modify permanent injunction granted by District Court to order reimbursement for abortions fundable under the Hyde Amendment. On remand from Seventh Circuit, No. 77C-4522 (N.D.9111.), court held that Hyde Amendment violated 5th Amendment to Constitution.

C. Cases Involving Other Medical Services

Curtis v. Page

U.S. District Court (N.D. Fla.) No. TCA 78-732, April 18, 1979.

Challenge to Florida's limitation on physicians' services to three visits per month except in emergency, as in violation of Title XIX. Court enjoined state defendants from implementing state policy, holding that although Title XIX does not require that all medically necessary services be provided under a state plan, it does require that the state's decision as to what services will be covered be reasonable and consistent with the objectives of Title XIX. Florida's limitation not reasonable because:

(1) the coverage provided is not "sufficient in amount, duration, and scope to reasonably achieve" the purpose of Title XIX;

(2) the limitation is contrary to the requirement that services not be reduced or denied "solely because of the diagnosis, of illness, or condition"; and

(3) the limitation bases eligibility on the disorder from which the patient suffers by wholly denying payment for medically necessary services if the patient has three times previously made reimbursable visits to a physician.

Dist. of Columbia Podiatry Society v. Dist. of Columbia

407 F.Supp. 2159 (D.D.C. 1975)

District Court held that a fee schedule and limitation on scope of podiatry services which were reimbursable under Medicaid were reasonable limitations on scope of optional service — state can set level of benefits and is not required by §1396(a)(6) to pay for every service a podiatrist authorized to perform. Court emphasized that Medicaid funds are appropriated to enable each state "as far as practicable" under the conditions in such state to furnish Medical Assistance and services. Intent of Congress to give states considerable discretion. Defendants' motion for summary judgment allowed.

Dodson v. Parham

427 F.Supp. 97 (N.D.Ga. 1977)

Action to enjoin state's use of a drug list restricting number of drugs reimbursable by Medicaid. Preliminary injunction issued. Court held that although plaintiff recipients did not have property interest in continued receipt of particular drugs as a matter of due process, plaintiffs did have legitimate claim for entitlement to receive drugs sufficient to achieve purposes of Medicaid program, 45 C.F.R. §249.10(a)(5)(i). Relied on evidence of

physicians who testified that the list was inadequate on its face because it did not contain some drugs doctors felt necessary to treat certain conditions. Thus Court accepted reasoning that state must pay for medically necessary drugs, although did not analyze as a "medically necessary" case.

Virginia Hosp. Assoc. v. Kenley

427 F.Supp. 781 (E.D. Va. 1977)

Challenge to Virginia state plan provision limiting Medicaid reimbursement to 21 days in hospital. District Court held limitation reasonable and rationally related to state's legitimate interest in insuring fiscal solvency of Medicaid program; did not violate any provision of Medicaid statute or regulations including the regulation 45 C.F.R. §249.10(a)(5)(i) which requires that services under the state plan be sufficient to "reasonably achieve their purpose." In its analysis, court rejected argument that state must pay for all medically necessary services. Judgment for defendants.

White v. Beal

555 F.2d 1146 (3rd Cir. 1977)

Pennsylvania regulation limited expenditure for eyeglasses on basis of etiology rather than medical necessity; District Court enjoined as in conflict with

federal statute and Court of Appeals affirmed. Held state has to provide eyeglasses if medically necessary; cannot treat recipients differently depending on condition, 45 C.F.R. §249.10(a)(5)(i).

II. CASES DISCUSSING DUE PROCESS ENTITLEMENTS UNDER MEDICAID.

Bracco v. Lackner

462 F.Supp. 436 (N.D. Calif. 1978)

Plaintiffs, Medicaid residents residing in nursing home, sought injunction against decertification of home without prior due process hearing. Court held that Medicaid recipients had a right to a hearing prior to any action resulting in supervision, reduction, discontinuance or termination of assistance under 45 C.F.R. 205.10(a)(5), and decertification of a facility was within the scope of that regulation, relying on Klein v. Mathews.

Klein v. Califano

586 F.2d 250 (3d Cir. 1978), affirming Klein v. Mathews, 430 F.Supp. 1005 (D.N.J. 1977)

Court affirmed District Court's holding that HEW could not terminate payments to a decertified nursing home until it gave residents of the home a due process hearing on the issue of the validity of the

decertification finding. Court held that termination of federal financial participation to nursing home and the concomitant forced transfer of Medicaid residents to other nursing care facilities would deprive residents of interests protected by due process clause of Fifth Amendment. The right found is one to continued occupancy of a particular home, not merely, as HEW argued, to continued receipt of government assistance for care rendered by qualified providers. Court held that the source of this right was "the statutory provision permitting a recipient to obtain medical care from a freely selected provider and the regulations prescribing limited conditions for transferring a resident of a nursing home..."

Newfield House, Inc. v. Commonwealth of Massachusetts, et al.

U.S. District Court (D. Mass.) C.A. No. 76-3742-G

Plaintiff nursing home which refused to sign a provider agreement and voluntarily withdrew from the Medicaid program brought suit to require the state defendants to assume responsbility of transferring Medicaid recipients who were residents of the facility. Plaintiff named federal HEW official as defendant as well. Plaintiff's complaint also alleged that the

patients could not be transferred before they received notice and a hearing. In an opinion granting the federal defendant's motion to dismiss (March 28, 1979), the District Court held that no due process hearing was required in this case because it did not concern any "action taken by the federal defendants... which would be the subject of a hearing." State defendants' motion to dismiss or, in the alternative, for summary judgment, pending.

Roberson v. Wood

U.S. District Court (E.D. Ill.) Civ. No. 78-4321

January 18, 1979.

Plaintiffs, two residents of a nursing home, brought suit against administrator of home and Director of Illinois Department of Public Aid to enjoin planned transfers by the home to another facility. Plaintiffs alleged that transfers without hearing violated Title XIX. Court denied motions to dismiss by both private and state defendants and found in Title XIX a property right in plaintiffs to remain in home of their choice until they were given a due process hearing. Court applied Klein v. Califano reasoning although, in this case, nursing home administrator planned the transfer, not the state defendants.

Town Court Nursing Center, Inc. v. Beal
586 F.2d 280 (3d Cir. 1978), cert. granted sub. nom. O'Bannon v. Town Court Nursing Center, Inc., 47 U.S.L.W. 3683 (April 6, 1979)

Plaintiffs, Medicaid recipients and patients at a nursing home, had sought and obtained injunction against defendants' decertifying nursing home and transferring them before providing them with a due process hearing. Third Circuit relied on decision issued in Klein v. Califano on same day and remanded to District Court for a determination of what procedures would satisfy constitutional rights of recipients prior to decertification of home.